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The Impact of Beauty, Body Image, and Health Discourses on Eating Disorder Risk in South Asian-Canadian Women

Nazia Bhatti

The University of Western Ontario

Supervisor

Treena Orchard

The University of Western Ontario

Graduate Program in Health and Rehabilitation Sciences

A thesis submitted in partial fulfillment of the requirements for the degree in Master of Science

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Abstract

This study explores socio-cultural influences that impact South Asian women's self-perceptions and eating behaviours. The findings revealed that cultural gender ideologies play a substantial role in shaping the way women view themselves and their bodies. The analysis of interviews conducted with seven South Asian-Canadian women between the ages of 19 to 29 years, demonstrate that women's perceptions of their own physical appearance is framed within the context of their South Asian cultural identity and cultural norms. This study examines cultural and gendered factors that contribute to South Asian women's increased risk for developing eating disorders. Notions of beauty and body, the cultural importance of marriage, and social commentary appeared to amplify the degree to which women experienced body dissatisfaction and influenced them to monitor their bodies and modify their eating behaviours to meet social and cultural expectations. Cultural ideologies that defined beauty, most notably skin tone and body shape/weight, were described by the participants as attributes of their physical appearance that they struggled with managing. Social commentary by other South Asian people also had a significant impact on the way South Asian women perceived their bodies. Criticisms about their body shape or weight, and the darkness of their skin tone were common elements of negative commentary they received. These characteristics of South Asian beauty ideals appeared to be associated with a woman's aptness for marriage. Beauty was associated with the ability to find a husband that ranked high on social status, wealth, and attractiveness.

Keywords: South Asian, women, eating disorders, body image, health, disordered eating, body shaming, social commentary, gender, beauty, biculturalism

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Table of Contents

Abstract	I
Acknowledgments.....	II
Table of Contents	III
List of Appendices	VI
Chapter 1 - Introduction.....	1
1 Introduction	1
1.1 Chapter Outline.....	6
Chapter 2 – Literature Review	10
2 INTRODUCTION	10
2.1 Gender, Body Image and Eating Disorders in South Asian Women	10
2.1.1 Gender Roles and Marriage	10
2.1.2 Body Image	11
2.1.3 Eating Disorders.....	13
2.2 Food, Eating and Health	17
2.2.1 Food & Nutrition.....	17
2.2.2 Social Significance of Food and Cooking	19
2.3 BICULTURALISM, ACCULTURATION AND CULTURAL CONFLICT.....	20
2.3.1 Acculturation and Conflict Between Western and South Asian Cultures	20
2.3.2 Parental Control and Cultural Conflict Over South Asian Women’s Autonomy ..	23
2.4 CONCLUSION.....	25
Chapter 3 - Methods.....	28
3 INTRODUCTION	28
3.1 Narrative Inquiry.....	29
3.2 Participants and Recruitment	30
3.3 Data Collection	32

3.4 Data Analysis	36
3.5 Quality Criteria	38
3.6 Ethical Considerations	38
3.7 CONCLUSION.....	40
Chapter 4 - Findings.....	41
4 BEAUTY, BODY IMAGE AND HEALTH	41
4.1 INTRODUCTION	41
4.2 BEAUTY	42
4.2.1 Definitions and Key Elements of Beauty.....	42
4.2.2 Cultural Significance of Beauty and Marriage	43
4.3 BODY IMAGE	45
4.3.1 Socio-cultural Commentary	45
4.3.2 Individual Management and Surveillance of the Body.....	49
4.4 HEALTH.....	51
4.4.1 Social and Familial Influences on Health and Eating Behaviours.....	52
4.4.2 Dieting and Restrictive Eating Behaviours	54
4.4.3 Impact of Culture on Eating Behaviours	57
4.5 CONCLUSION.....	62
Chapter 5 - Findings.....	64
5 BEAUTY, BODY IMAGE AND HEALTH	64
5.1 INTRODUCTION	64
5.2 Socio-Cultural Significance of Body and Gender	65
5.3 Social Commentary and Body Shaming	67
5.4 FOOD, EATING AND HEALTH	70
Chapter 6 – Conclusion.....	73
5.5 Limitations/Future Directions	75
5.6 Recommendations.....	76

Bibliography	78
Appendices	86
Curriculum Vitae	127

List of Appendices

Appendix A - Informed Consent & Letter of Information.....	86
Appendix B - Research Ethics	92
Appendix C - Interview Guide.....	119
Appendix D - Vignette	121
Appendix E - Recruitment Poster	123
Appendix F - DSM-V Eating Disorder Classifications	124

Chapter 1 - Introduction

1 Introduction

Body dissatisfaction and body image issues, including discontent with body size or physical differences, such as skin colour, are common among young women (Javier & Belgrave, 2015; Reddy & Crowther, 2007; Want & Saiphoo, 2016). Cross-cultural research in this area has revealed that women with certain cultural backgrounds report greater degrees of body dissatisfaction than others (Wildes et al., 2003). Comparison studies that examine the differences in eating disorder pathology among Caucasian, African, Latin and Asian women, found that South Asian women in particular report greater dissatisfaction with their bodies and more instances of eating disturbances (Iyer & Haslam, 2003; Javier & Belgrave, 2015; Kennedy et al., 2004; Mujtaba & Furnham, 2001; Mumford et al., 1992, Mumford et al., 1991; Reddy & Crowther, 2007). Research specifically examining eating disorders in South Asian women have examined the extent to which body image issues and eating disturbances relate to cultural ideologies of body image, internalization of body ideals, eating attitudes, acculturation, cultural conflict, familial conflict, and perceived lack of control (Furham & Adam-Saib, 2000; Hill & Bhatti, 1993; Iyer & Haslam, 2003; Mujtaba & Furnham, 2001; Mumford et al., 1992; Mumford et al., 1991; Mustafa et al., 2016). South Asian women ranked higher than any other ethnic group for each of these issues, which have also been identified as factors that put South Asian women at higher risk for developing eating disorders. It has been suggested that this can be explained through reference to the differences or clashes between South Asian and North American cultures and norms (Reddy & Crowther, 2007; Kennedy et al., 2004; Iyer & Haslam, 2003; Mujtaba & Furnham, 2001; Mumford et al., 1992; Mumford et al., 1991), however, there remains a dearth of qualitative research that explores other cultural factors like ideas of beauty, body, and health among young South Asian women.

The present study contributes to the research literature, which is currently quite small in scope, that explores the complex lived realities that shape young South Asian women's vulnerability to eating disorders and the gendered, as well as socio-cultural factors, that inform these aspects of life. Specifically, this study aimed to understand disordered eating and body dissatisfaction among South Asian women within the context of social, cultural, and gender roles. The following research questions were designed to provide the conceptual framework for my study: 1) What role does body perception, gender and culture play in young women's experiences with eating disorders? and 2) How do young South Asian women locate these experiences within their broader understanding of health? There is a need to further explore the impact of gender and cultural norms on South Asian women's self-perceptions and body satisfaction, and the extent to which socio-cultural traditions influence the development of eating disorders for this at-risk population of women.

Over the past two decades eating disorders have been on the rise among Canadian women between the ages of 15 to 24 (Canadian Institute for Health Information, 2014; Keel, 2010; Makino et al., 2004). Eating disorders are a group of serious conditions that involve a preoccupation with food and weight, leading to serious physical and mental problems (Gordon et al., 2010). This thesis focuses primarily on three conditions: anorexia nervosa, bulimia nervosa, and eating disorders not otherwise specified (EDNOS) as it is defined in the fourth edition of the *Diagnostics and Statistical Manual (DSM-IV-TR)*. The term 'eating disorder' is often referred to in accordance with the *Diagnostics and Statistical Manual (DSM-IV-TR)* definitions, and implies a psychological and physical pathology with symptoms that are characterized by three main classifications of disorders: anorexia nervosa, bulimia nervosa, and eating disorders not otherwise specified (EDNOS), which includes any eating disorders that do not fall under the definitions for anorexia nervosa or bulimia nervosa (Gordon et al., 2010). Although there is a revised fifth edition of the *Diagnostics and Statistical Manual* released in 2013, in this thesis I

will be referring to *DSM-IV-TR*, as the time this study commenced it was the edition that framed the perspectives discussed here. The *DSM-V* will also be referenced in terms of the future implications it has for the health of South Asian women at risk for disordered in eating.

The *DSM-IV-TR* provides definitions for each disorder and the set of symptoms that are required for clinical diagnoses (Gordon et al., 2010). An individual diagnosed with anorexia nervosa exhibits signs of refusing to eat, restricting food intake or engaging in bingeing and purging behaviours, and not maintaining a normal body weight (Franco, 2000). Other symptoms include an intense fear of gaining weight, a distorted body image, denial of severity of their low body weight, and the absence of three consecutive menstrual cycles (Franco, 2000). It is also common for people with anorexia nervosa to exhibit anxiety, depression, and obsessive compulsive behaviours, such as obsessive thoughts about food, portioning or picking at food, and food hoarding (Franco, 2000). Bulimia nervosa is characterized by episodes of eating large amounts of food, in quantities that are much greater than one would normally consume in a specified time period, followed by inappropriate compensatory behaviours to avoid weight gain, which can include the use of laxatives, induced vomiting, and excessive exercise or fasting (Franco, 2000).

The primary difference between anorexia nervosa and bulimia nervosa is that people with bulimia nervosa typically maintain a body weight close to normal, whereas those with anorexia nervosa are underweight and experience other severe physical symptoms, such as organ damage (Franco, 2000). Eating disorders not otherwise specified (EDNOS) is a category in which other disordered eating behaviours fall into when they do not meet the specific criteria outlined by anorexia nervosa or bulimia nervosa (Franco, 2000). When discussing EDNOS or any unhealthy eating behaviours that do not fit the clinical definitions in the *DSM-IV-TR*, researchers refer to these behaviours as ‘eating disturbances’ or ‘disordered eating’ to describe the risky behaviours that can lead to clinical eating disorders (anorexia nervosa, bulimia nervosa). The literature

typically refers to anorexia nervosa and bulimia nervosa as ‘eating disorders’ because they are considered to be more severe conditions that are diagnosed as diseases or disorders, whereas EDNOS are often referred to as ‘eating disturbances’ in the literature on eating disorders in South Asian-Canadian women, as they are moderate, yet still problematic, conditions that do not meet the criteria for clinical diagnoses or treatments defined in the *DSM-IV-TR*. An EDNOS, according to the *DSM-IV-TR* could present with a range of symptomology such as restricting certain foods (i.e. eliminating carbohydrates), to presenting with all of the symptoms as anorexia nervosa with the exception of one criterion (i.e. may not experience complete cessation of menses). The broadness of the criteria of EDNOS can have serious implications for women that are suffering from disordered eating. Because practitioners use the *DSM-IV-TR* to make diagnoses of mental health disorders, it can be easy to overlook the signs and symptoms of eating disorders that are negatively impacting women’s physical and mental health.

Body image and eating disorders are interconnected phenomena that usually coexist. People who experience negative attitudes about their body appearance and feel they are overweight, for instance, can manipulate their eating behaviours by portion-controlling their food, restricting themselves from eating, and engaging in bingeing and purging patterns to control their weight and attain a desired body shape. Eating disorders have several physical implications for young women, including short-term and long-term problems for their physical health, including hypertension, diabetes, dyslipidemia, electrolyte imbalances, endocrine disorders, anemia, dehydration, infertility, and kidney failure to name a few. They can also produce significant psychological and/or mental health problems, such as depression, anxiety, substance abuse, and suicide (Gucciardi et al., 2004). Such health problems can severely impact quality of life and productivity among women in their personal and professional lives and eating disorders are aspects of life many continue to struggle with alone, given the very private nature of these issues. Given this, for many women, their eating disorders go untreated or help is sometimes

sought only when their physical health is severely affected and hospitalization is required (Bradby et al., 2007; Gucciardi et al., 2004).

A review of the sociological, psychological, and health sciences literature on eating disorders and body image examines the phenomena from the perspective of White females of North American or European decent, and focuses on issues of prevalence, risk and protective factors for disordered eating and body image among females. Cross-cultural comparison studies have examined particular ethnicities' propensity to eating disorders, and results have shown that eating disorders are a greater concern for some ethnic groups than they are for White women (Keel, 2010). In response to the findings of cross-cultural studies on eating disorders, further research among ethnic populations has become a growing area of interest and concern (Keel, 2010). Current research is now expanding examination of eating disorders in ethnic populations, with particular focus on South Asian women and adolescent girls to understand why eating disorder prevalence is higher among this population (Keel, 2010).

Some socio-cultural studies suggest that the prevalence and risk of disordered eating behaviours is greater among South Asian women than White women, and largely due to acculturation to Westernized dominated ideals of body appearance (Iyer and Haslam, 2003; Furnham and Adam-Saib, 2001; Reddy & Crowther, 2007; Mumford et al. 1992; Mumford et al. 1991). Research examining the influence of acculturation on body image suggests that eating disorders can develop when people of non-Western cultures assimilate to or adopt Western norms of body weight and shape, particularly those favouring thinner physiques, and strive to attain an "ideal" body image to fit in with the dominant Western culture (Reddy & Crowther, 2007). This is believed to have a significant impact on increasing the risk for eating disorders among ethnic minority females (Reddy & Crowther, 2007). However, psychological and socio-cultural factors have also been shown to influence eating disorder risk in South Asians (Anand & Cochrane, 2005; Mumford et al., 1991; McCourt & Waller 1996; Kennedy et al., 2004),

including cultural norms, familial and peer relationships, and struggles with balancing traditional South Asian gender and cultural values while living in Western societies may have a stronger influence on eating disorder risk in South Asian women.

Eating disorders can be transmitted among family members and problematic eating can affect the psychological well-being and eating patterns of children who witness their parents or siblings battle with disordered eating (Gucciardi et al., 2004). Not only are these children more susceptible to adopting irregular eating patterns, detached experiences during mealtime, and non-nutritive associations with food, significant body dissatisfaction and low self-esteem can also result (Gucciardi et al., 2004). In response to an increasing number of cases of eating disorders among children and adolescents globally, the World Health Organization (WHO) made eating disorders a primary area of focus beginning in 2003. Because eating disorders tend to begin in the early stages of life and progress into adulthood, the WHO aimed to address the problem as early in life as possible (Keel, 2010). Thus, it is important to understand how inter-familial and socio-cultural factors related to food, eating, and health shape disordered eating experiences among young women, particularly those living in multi-cultural settings where ethnic differences between natal and ‘western’ cultures exert considerable tension in their daily lives.

1.1 Chapter Outline

This thesis will begin with a discussion of the relevant research literature into eating disorders in South Asian women and look at key areas of interest highlighted in the health science, sociology and psychology literature. A review of the findings drawn from previous studies in the fields of sociology, psychology, and health sciences will be presented to help explain the factors that potentially influence the development of eating disorders in South Asian women. Across the literature, acculturation to Western values and norms emerged as a major theme that is thought to impact South Asian women’s struggle with balancing their traditional cultural and gender values with Western cultural and gender norms. The struggle with acculturation, in particular, has been

identified as leading to cultural dissonance among many of these young women who strive to create an identity in the face of conflicting value systems. South Asian women reported having greater conflicts with parents, particularly relating to opposing cultural values. Strict parental control and South Asian women's perceived lack of control over their lives are cited as facilitating factors in the development of disordered eating behaviours.

Next, a discussion of the methods used in this study will be presented, including the recruitment process, study sample, data collection methods, data analysis, quality criteria, and ethical considerations that guided this study. This study used qualitative research methods, specifically narrative inquiry, to explore the social, cultural and gender roles that emerged in the women's lived experiences with disordered eating. This method was chosen because it enabled me to collect thick, descriptive data through open-ended conversations with my participants. The interview process was an intimate, safe exchange between myself and my participants, that opened up the possibility to explore in-depth and with much candor, the deep and complex meanings that women give to their experiences. The qualitative approach also addresses a gap in the current body of literature in this field, as most of the existing research focuses on prevalence rates, degree of severity of eating disorders, and identifying potential contributing factors that influence disordered in the female South Asian population without exploring in-depth the context within which disordered eating behaviours occur for South Asian women.

During my research I examined the lived experiences of young South Asian women and their perspectives on cultural norms and values surrounding beauty, body image and health. I interviewed seven first-generation South Asian women between the ages of 19 to 29 years old. They all discussed their perceptions of what constitutes beauty in South Asian culture, and identified key characteristics that they felt best-defined female beauty. Slender body shape, hair (including body hair), and light skin tone were the most prominent characteristics they felt women needed to possess in order to be considered beautiful according to ideals in South Asian

culture. The women discussed their struggles with aiming to achieve these ideals, how it impacted their self-esteem, and how their strive to be beautiful negatively affected their health.

In spite of the expanding knowledge on eating disorders in South Asian women, there remain gaps in understanding the socio-cultural and psychological mechanisms that are involved. Currently there is a lack of research examining the lived experiences of South Asian women with eating disorders, which has the potential to unpack some of the underlying socio-cultural factors that are thought to impact eating disorder pathology in young South Asian women. I aimed to examine the lived experiences of young South Asian women to gain an understanding of how culture and gender is experienced from the perspective of South Asian women living in Western society. Of primary interest is how their experiences have influenced the way they perceived their bodies and interacted with their environment, including how they patterned their eating behaviours and social interactions, as well as understand what impact this had on their physical and mental health. These issues have shown to have a significant effect on this population but are not often openly discussed (Anand & Cochrane, 2005; Hill & Bhatti, 1993; Kennedy et al., 2004, Khandewal et al., 1995; McCourt & Waller 1996; Mumford et al., 1991; Mumford et al., 1992; Reddy & Crowther, 2007). A study of this nature is an important contribution to the extant literature on eating disorders in South Asians women, as it further explores and contextualizes areas, such as cultural dissonance, that current research identifies as risk factors for the development of problematic eating behaviours from the perspective of those who experience it firsthand.

This study contributes to the current body of literature on eating disorders in South Asian women, and begins to provide an understanding of how young South Asian women locate their experiences with disordered eating and body image perceptions in relation to current assumptions about eating pathology and health. A narrative study that examines the experiences of eating disorders in South Asian women can inform new directions for health services and

preventative programs tailored to meet the specific needs of this population that may not be addressed with existing programs. For instance, cognitive behavioural therapies may not be addressing ethnic differences underlying the issue. In addition, there is the potential to explore areas of health education for women on eating disorder risks and prevention, and empower women to effectively manage their health in the face of cultural or gender dichotomies.

This thesis will discuss the findings from a narrative analysis of South Asian-Canadian women's experiences with disordered eating behaviours. To better understand the context of the women's experiences, a literature review highlighting prominent research in this field will provide a background of the theoretical groundwork that has guided this study's epistemological and ontological framework, followed by the presentation of this study's methodology, findings, and a discussion of how the findings contribute to the existing body of literature.

Chapter 2 – Literature Review

2 INTRODUCTION

This chapter features the relevant sociological, psychological, and health sciences literature on eating disorders among South Asian women, beginning with a discussion of the ways in which female gender roles shape women's ideas about their bodies, their identities, and the kinds of eating disorders they experience. I then discuss the role of food and eating in South Asian culture in terms of social and cultural practices related to food and meal preparation, which are issues that emerged as very powerful factors in the lives of South Asian women. Next, I explore how competing cultural influences among South Asian women living in multicultural settings, namely between traditional South Asian and dominant Western ideals, factor into the risks these women face regarding eating disorders and a compromised sense of well-being or health.

2.1 Gender, Body Image and Eating Disorders in South Asian Women

2.1.1 Gender Roles and Marriage

To understand the issues that impact disordered eating among South Asian women it is important to situate their experiences within the broader cultural context, namely how gender and body ideologies influence their self-perceptions and embodied surveillance. While my focus is primarily on how gendered ideas and practices impact women, because South Asian and Western cultures are deeply patriarchal societies some contextualization of how men shape the lives of women and female gender roles is also relevant to this discussion. Traditionally, in South Asian culture men are considered leaders of the household and they exercise a great deal of power over their families, including women's access to financial resources, their mobility, and in some instances their independence and personal freedom, particularly outside of the home (Fikree and Pasha, 2004). Yoshihama & Dabby (2015) estimate approximately 40% of South Asian women

experience physical, sexual, and emotional violence at the hands of the men in the household. A common reason for the perpetration of violence against women was due to failure to conform to expected familial and gender roles (Fikree and Pasha, 2004). This is especially true in families that hold traditional conservative cultural values, where women often experience greater pressures in their daily lives because of the many expectations to uphold traditional gender roles, particularly those related to arranged marriages. Among families that uphold this tradition, women often have little or no say in whom or when she marries because the family usually makes these important decisions on their behalf (Fikree and Pasha, 2004). For women in these situations there are significant struggles with cultural dissonance for those who have been brought up with and influenced by Western culture alongside traditional South Asian values and beliefs (Furnham & Adam-Saib, 2001; Iyer & Haslam, 2003; Katzman & Lee, 1997; McCourt & Waller, 1996). Cultural conflicts between women and their families can lead to internalized feelings of powerlessness, reduced autonomy and an inability to control their own lives, all of which are cited as risk factors for eating disorders in South Asian women (Anand & Cochrane, 2005; Hill & Bhatti, 1993; Iyer & Haslam, 2003; Katzman & Lee, 1997; Kennedy et al., 2004, Khandewal et al., 1995; McCourt & Waller, 1996; Mumford et al., 1991; Mumford et al., 1992; Reddy & Crowther, 2007). The phenomenon of cultural conflict will be explored in greater detail later in this chapter.

2.1.2 Body Image

Body image is defined as “the way people perceive themselves and...the way they think others see them.” (Bush et al., 2001, p.208). For many South Asian women body image is impacted by an ongoing struggle to maintain an ideal body weight/shape or other aspects of their physical appearances, such as skin tone. It can be challenging for women to determine when they have achieved an ideal body image as the notion of an ideal body and appearance is fluid and

dependant on socio-cultural norms and values of a particular population or sub-group which can change over time.

Skin tone is used to assess South Asian women's socio-sexual desirability as well as their suitability as a candidate for an arranged marriage. In South Asian cultures, as well as many Asian cultures that were colonized by Europeans, fair or light skin is viewed as a quality associated with aristocratic lineage, whereas darker skin implies one is from the lower, working class (Shankar & Subish, 2007). The notion of 'fairness' as a desirable quality among South Asians arose from colonial beliefs when South Asia was colonized under British rule (Shankar & Subish, 2007). White European decedents were viewed as rulers and elites because they took on higher status positions in society, therefore, South Asians valued fairer skin tones as a symbol of wealth and power. Darker skin tone was associated with the poorer working-class people who were ruled by White elitists, and historically they would take on labour jobs working outdoors in fields and thus were exposed to longer periods in the sun which made their skin darker (Shankar & Subish, 2007). The notion that fair skin is more desirable is still upheld by many South Asians today, which remains evident in South Asian popular culture where darker skinned individuals are portrayed as lower-class citizens (Shankar & Subish, 2007).

In terms of body weight/shape, during the industrial revolution larger body sizes were associated with better health and nutrition, as it was believed that those who could afford to eat more were perceived as wealthy, therefore, among South Asian people living in developing countries it was more desirable to have full-figured body shapes (Bush et al., 2001). Families would seek fuller-bodied women for an arranged marriage because it was a reflection of wealth, higher social status, and good physical and reproductive health (Bush et al., 2001). However, in post-industrial settings with the increases in food accessibility and economic advancement in South Asian countries, a shift has occurred. The associations between body shape and health now favour thinness, which is often thought to represent self-control and as being in line with

dominant models of both beauty and health (Bush et al., 2001). The historical ideas about larger body shapes is less evident among South Asians today, and the modernization of body image ideals that is common among women in Western societies has largely taken over to promote thinner body shapes. One of the outcomes of this shift in orientation of body image and the desire to be thin is the development of disordered eating. Eating restraint is more commonly practiced and is becoming a significant issue for South Asian women living in Western societies, and eating disorders are becoming more prevalent among young South Asian women (Anand & Cochrane, 2005; Hill & Bhatti, 1993; Kennedy et al., 2004, Khandewal et al., 1995; McCourt & Waller, 1996; Mumford et al., 1991; Reddy & Crowther, 2007).

2.1.3 Eating Disorders

Eating disorders, specifically anorexia and bulimia, are believed to be culturally influenced phenomena driven by an obsession with thinness and small body size (Furnham & Adam-Saib, 2001; Mujtaba & Furnham, 2001; Mumford et al., 1991; Rohde et al., 2015). Among women between the ages of 15 and 65, the lifetime prevalence of diagnosed eating disorders is 1.1% (Gucciardi et al., 2004), which does not appear to be all that significant. However, many women with disturbed eating behaviours do not seek treatment, and among those who do, they may not meet the diagnostic criteria for an eating disorder according to earlier versions of the *Diagnostics and Statistical Manual of Mental Disorders (DSM)*, which means many cases of disordered eating were not classified as an eating disorder and the actual prevalence of eating disorders is likely much higher (Agras, 2010). This is also relevant for South Asian women who consistently under-report and under-utilize mental health services and treatment owing to stigma surrounding mental health issues, including eating disorders, which are often not acknowledged as a serious health concern (Anand & Cochrane, 2005; Javier & Belgrave, 2015; Mustafa et al., 2016). Therefore, the number of South Asian women and girls affected by unhealthy eating behaviours is likely greater than reports suggest.

Much of the Canadian literature on eating disorders among women discuss the issues of skewed body image or body dysmorphia, and a drive to achieve and maintain what is often an unrealistic body weight and shape (Gucciardi et al., 2004). In Canada, 34% of prepubescent girls, and 76% of post-pubescent girls reported being dissatisfied with their body shape, and engaged in unhealthy weight-management behaviours, such as dieting, starvation, smoking and the use of weight-loss drugs to achieve an “ideal” body image (Gucciardi et al., 2004). This is concerning, not only considering the age at which these behaviours begin, but also because of the severe negative impact that these behaviours have on the health of young girls, as it compromises their physical and mental growth and development, and can greatly increase the risk for eating disorders and related conditions like depression and anxiety disorders (Gucciardi et al., 2004; Hill & Bhatti, 1993).

It is not clear what the determining factors are for the heightened eating disorder risk among South Asian women as compared to women of other ethnicities, however, some research suggests that the influence of Western culture impacts the way women think and feel about their bodies. Acculturation theories of eating disorders in South Asian women examine the degree to which body dissatisfaction is influenced by Westernized cultural ideals of female body types, specifically for South Asian women living in Western societies. Studies have found that South Asian women with more traditional cultural values report engaging in more unhealthy eating behaviours than non-South Asian women, suggesting that there may be culturally-specific factors that influence South Asian women to engage in disordered eating behaviours (Hill & Bhatti, 1993; Furnham & Adam-Saib, 2001; Kennedy et al., 2004; Mumford et al., 1991). Reddy and Crowther (2007) suggest that young South Asian women living in North America deal with more stresses and pressures to be more like their White peers in terms of their appearance, such as having lighter skin and slimmer body shapes. Women then strive to fit in with peers by adapting their appearances, or expressing a desire to alter their bodies to make themselves more like their

White peers in order to identify more with Western culture than their culture of origin (George & Rail, 2005). In their study, George & Rail (2005) found that several South Asian women in some way altered their bodies to appear “less South Asian”. For instance, several women conceded to undergoing cosmetic routines, such as skin bleaching to lighten their complexion, and these cosmetic routines were viewed by South Asian women as a normal and necessary way of living for all South Asian women (George & Rail, 2005.). Iyer & Haslam (2003) suggest there is a link between negative comments about one’s ethnic appearance and eating disorder risk, because comments highlighting ethnic differences lower women’s self-esteem and increases their desire to change their physical appearance. Since some physical traits are not as easily altered, such as skin colour, it is thought that women instead alter traits that are within their control, such as weight and body shape, as a way of boosting their self-esteem and feeling as though they have changed to appear more like their White peers (Iyer & Haslam, 2003). Thus, South Asian women living in Western society are more willing to take drastic actions, such as extreme dieting, to alter their appearances to fit in with their White peers, and this could potentially be a factor contributing eating disorders for some South Asian women.

Cross-cultural research on eating disorders demonstrate that White women and South Asian women vary in their experiences with eating disorders and South Asian women are at greater risk of developing an eating disorder (Gupta et al., 1999; Hill & Bhatti, 1993; Kennedy et al., 2004; Mumford et al., 1991; Solmi et al., 2014). For instance, South Asian women with eating disorders often report greater body satisfaction than White women with eating disorders, however, the reasons for discrepancies have not been definitively identified and there are various explanations suggested in this body of work (Furnham & Adam-Saib, 2001; Hill & Bhatti, 1993; Kennedy et al., 2004; Mumford et al., 1991). One explanation provided is that earlier editions of the *Diagnostics and Statistical Manual’s* definitions for eating disorder classifications may not apply to South Asian women’s eating disorder symptomology (Keel, 2010). For instance, the

requirement for a clinical diagnosis of anorexia includes a fear of weight gain, however, the ‘fear of fatness’ is not a risk factor reported by South Asian women with eating disorders (Hill & Bhatti, 1993; Kennedy et al., 2004; Khandelwal et al., 1995; Mumford et al., 1991). The absence of this criterion in South Asian women’s experiences might suggest they do not experience eating disorders or psychological impairments in the same way as other populations, which is a critical factor for health professionals to consider when assessing disordered eating among women from South Asian (and other) cultures, which is where the *DSM-IV-TR* and earlier versions fell short in capturing the unique experiences of these populations.

In May 2013, the *DSM* released a fifth revised version of the manual to include diagnostic criteria and categories that are more inclusive of various types of feeding and eating disorders (American Psychiatric Association, 2013). The *DSM-V* has re-classified some feeding disorders that were previously categorized under other types of mental disorders in the manual, but have now included feeding disorders with expanded criteria to classify it as a class of eating disorder for more accurate diagnosis by health professionals (Appendix F). The changes made also include updates to the diagnostic criteria for anorexia nervosa to be more inclusive of behaviours that tend toward a resistance to weight gain, and the addition of avoidant/restrictive food intake disorders which previously focused on feeding disorders in infancy and childhood but now applies to people in any stage of life (American Psychiatric Association, 2013). Another notable change is the removal of ‘Eating Disorders Not Otherwise Specified’ (EDNOS) which broadly classified any other types of disordered eating that did not fall within the diagnostic criteria of other eating disorder categories. This was replaced with two new categories: ‘Other Specified Feeding or Eating Disorder’ (OSFED) and ‘Unspecified Feeding and Eating Disorder’ (UFED) (American Psychiatric Association, 2013). With the updates in the *DSM-V* eating disorder criteria, more cases of disordered eating in women can potentially be identified as

clinical conditions and treatment options would be more readily available¹. The vague criteria that outlined specific conditions in the previous editions did not provide clear guidelines for diagnosing professionals to determine whether a person was classified within the parameters for an eating disorder. Although *DSM-V* offers more inclusive criteria in which more cases of eating disorders could be identified by health practitioners, there still remains the issue that eating disorders among South Asian women continue to be under-reported due to the stigma associated with mental health disorders (Mustafa et al., 2016).

2.2 Food, Eating and Health

In South Asian culture, food is an integral part of interactions with families and friends. It is a way of creating identities, and South Asians have a strong sense of identity through not only the types of foods and cultural dishes served, but also what food represents socially, culturally and religiously (Fikree and Pasha 2004). The literature in the field of sociology has examined the links between food, health and well-being, and cultural significance of food for South Asian people in social and familial contexts (Chapman et al., 2011; Chowbey, 2017).

2.2.1 Food & Nutrition

A common belief among South Asian women living in Western societies is that North American or European diets are ‘healthier’ compared to traditional South Asian cuisine (Chapman et al., 2011). In a study by Chapman, Ristovski-Slijepcevic and Beagan (2011), that examined South Asians Canadians’ perspectives on the meanings of food and well-being found that many people

¹ While the changes to the *DSM* allow better recognition of eating disorder pathology by health professionals, from the perspective of critical feminist theory, the new categories of *DSM-V* exemplify the increased medicalization of eating disorders that work to exert the power of those in the medical community. The creation of new categories for clinical diagnoses and treatments allow for the increased use of pharmaceuticals to treat *DSM* disorders, which is a private industry largely interested in financial gains. Increasing diagnoses of eating disorders can help the industry thrive, and this can be used as a way to create and control women’s ideas about themselves, their bodies, and their health.

described a ‘healthy’ diet as reflecting the recommendations of Canada’s Food Guide, and described the South Asian diet as lacking in meeting the nutritional requirements for Canadians because of the foods that are commonly consumed in South Asian cuisine. A Canadian diet was viewed as having a good balance of carbohydrates, protein, fats, fruits and vegetables, whereas the South Asian diet was described as rich in carbohydrates and fats, and consisted of few raw vegetables (Chapman et al., 2011; Choudhry, 1998). South Asian cuisine consists of starchy foods as a main dish, usually rice or roti (wheat flat breads), with curries that are cooked with meats, vegetables, or lentils cooked in oils, ghee (clarified butter), and sometimes high fat creams or milk (Chapman et al., 2011; Choudhry, 1998). Because Canadian cuisine promotes using less fats and starches and more proteins and raw vegetables, whereas South Asian cuisine tends to be higher in fats and starches, and lower in proteins and raw vegetables, South Asian food is viewed as being less healthy than Canadian foods (Chapman et al., 2011).

As a consequence of the nutritional makeup of South Asian foods, and to an extent the genetic predisposition for certain diseases, South Asian people are at greater risk for various health issues and chronic disease such as heart disease and type-2 diabetes (Chapman et al., 2011; Choudhry, 1998). Many South Asians are mindful of their health risks and try to manage their food intake by reducing the amount of fats used in meal preparation to reduce their risk of contracting a chronic disease (Chapman et al., 2011; Choudhry, 1998).

Being overweight and having fuller body shapes have historically been viewed as more favourable in South Asian cultures; however, as discussed earlier in the chapter, the notions of body shape and weight have shifted since the industrial revolution to align more with Western ideals of body that favour thin bodies. As with many populations, among South Asian Canadians being overweight is more commonly viewed negatively and is associated with being unhealthy (Choudhry, 1998). South Asians in Canada, especially women who experience insecurities about their weight and body, adopt eating habits that align more closely with Western perspectives on

food and nutrition (Chapman et al., 2011; Choudhry, 1998). For young females, accessibility to ‘healthier’ foods may be difficult due to the cultural practices around food and eating, where meals are prepared for communal sharing, which can lead young women to restricting their intake of cultural foods that are prepared for the family to avoid consuming high calorie foods that can cause to weight gain (Choudhry, 1998). The cultural significance of food and eating can lead young South Asian women to develop a complex relationship with food. This will be explored in the next section, where I highlight the cultural and social significance of food and eating in South Asian culture.

2.2.2 Social Significance of Food and Cooking

Meal preparation used to be, and in some families it still is, one of the main tasks for women in a South Asian household according to traditional gender roles. Women hold the position of leader of the household by taking care of their children and husbands by preparing meals and handling house chores (Chowbey, 2017; Choudhry, 1998). Food holds great significance in the context of the family unit in South Asian culture, as it used as a way to secure communal ties, nurture kin and others, and it is also part of entrenched cultural practices regarding religious/spiritual duties that are considered essential to interpersonal, familial, and even cosmic harmony (Chapman et al., 2011; Chowbey, 2017; Valliantos & Raine, 2008). The collectivist orientation among South Asian cultural groups ensures that the needs and desires of others are put first over the needs of the individual. So, for South Asian women who traditionally take on the sole responsibility of meal preparation for the family, food and cooking is viewed as way of demonstrating their love and gratitude toward the family (Chapman et al., 2011; Choudhry, 1998; Chowbey, 2017; Farver et al., 2002). Meal preparation entails an implicit display of affection, and in some cases discontent, for husbands and children. This is achieved through women’s choice of meals to prepare, being mindful of individual family members personal preferences (Chapman et al., 2011; Chowbey, 2017; Valliantos & Raine, 2008). For example, if women want to show their

appreciation for their husband or celebrate a special occasion they will prepare his favourite foods, however, if there was conflict between them women may refuse to prepare dishes of his preference and perhaps make a meal that the children prefer (Chowbey, 2017). In South Asian countries there are many instances of domestic disputes and violence related to meal preparation and the ways that women use food as a medium through which to resist the strains of life they experience, thus demonstrating the strong ties that the culture has to food as well as gendered expectations (Ali, 2012; Chowbey, 2017; Grover 2006).

2.3 BICULTURALISM, ACCULTURATION AND CULTURAL CONFLICT

2.3.1 Acculturation and Conflict Between Western and South Asian Cultures

Health and psychologically-driven research that explores the relationship between the forces of acculturation and eating disorders in South Asian women provide useful insights into the complex and often competing factors that play a significant role in these distressing behaviours among these young women. Acculturation, in this context, refers to the processes through which non-Western individuals absorb the norms and traditions of Western culture, which include adopting the thin body image ideals of Western culture (Gucciardi et al., 2004; Iyer & Haslam, 2003; Kennedy et al., 2004; Littlewood, 2004; Mujtaba & Furnham, 2001; Mumford et al., 1991; Reddy & Crowther, 2007; Waller & McCourt, 1996). Researchers who employ the acculturation framework to explain why South Asian women are at increased risk of developing eating disorders highlight the role of Westernized body ideals, specifically the idea that thin bodies are more desirable, which is adopted as the penultimate embodied goal over more traditional models of beauty or health (Anand & Cochrane, 2005; Hill & Bhatti, 1993; Kennedy et al., 2004, Khandewal et al., 1995; McCourt & Waller, 1996; Mumford et al., 1991; Reddy & Crowther, 2007). Although the relationship between acculturation and disordered eating has been identified, the extent to which it impacts eating disorder risk remains to be seen (Reddy &

Crowther, 2007; McCourt & Waller, 1996; Mujtaba & Furnham, 2001; Mumford et al., 1991; Mustafa et al., 2016).

To bring a more nuanced understanding of why South Asian women are at a higher risk of developing eating disorders, cultural conflict theories have been used to explain this increased risk. Cultural conflict refers to the “...negative affect (e.g. guilt, anxiety) and cognitive contradictions that results from contending simultaneously with the values and behavioural expectations that are internalized from the culture of origin [South Asian culture] and the values and behavioural expectations that are imposed on the person from the new culture” (Inman et al., 2001, pp.306). It is believed that differences between Western and South Asian cultures is a better way of understanding why South Asian women suffer from eating disorders more than other populations (Reddy & Crowther, 2007; McCourt & Waller, 1996; Hill & Bhatti, 1993; Mumford et al., 1991; Mujtaba & Furnham, 2001). Some cultural factors have been identified as having a stronger influence on disturbed eating behaviours. For instance, issues with eating behaviours are thought to manifest from the differences between Western and South Asian cultures in terms of the expectations placed on South Asian women to take into consideration the impact of their decisions on the family unit (the collectivist mentality) which puts a greater deal of pressure on women, whereas Western cultures promote individualization and independence for children (Chowbey, 2017; Valliantos & Raine, 2008; McCourt & Waller, 1996). Therefore, young South Asian women experience conflict between living independently within Western culture and making one’s own choices on matters that impact them personally, and having their independence restricted and choices dictated by South Asian families that hold traditional cultural values (McCourt & Waller, 1996). This creates struggles for control and balancing two conflicting value systems.

Another key issue that is considered in the research examining the impact that cultural factors have on eating disorders is the role of religion. A large majority of South Asians are

Muslim, Hindu, and Sikh. Interpretations of religious/cultural beliefs imply restrictions to a woman's independence, such as requiring her to dress conservatively as to not reveal too much skin, and strict rules against pre-marital male-female relationships (Ahmed et al., 1994; Mustafa et al., 2016). It is believed that religious values and rules that limit women's ability to live and make decisions independently can be a source of cultural conflict for young South Asian women living in Western societies (Ahmed et al., 1994; Mustafa et al., 2016). South Asian women that are brought up in Western society are taught from a young age to differentiate themselves from their Western counterparts, including refraining from associating with members of the opposite sex and being told that dating and engaging in sexual activity is forbidden by their religion (Mustafa et al., 2016). In order to protect women from engaging in prohibited behaviours parents instill strict rules and monitoring of women's actions to ensure that their cultural and religious values are being upheld (Ahmed et al., 1994; McCourt & Waller, 1996; Mustafa et al., 2016). Mustafa et al. (2016) hypothesized this as cultural-change syndrome where "...reconciling conflicting worlds, managing traditional family obligations and personal restrictions, and preserving traditional values and beliefs, makes it challenging for young [South Asian] women to create a self-identity and to find self-worth" (Mustafa et al., 2016, pp.44). Women internalize the conflict they experience between upholding traditional South Asian values and blending in with the dominant culture (Western), which results in manifesting complex psychiatric symptoms as a way to gain a sense of personal control, thus tending to disordered ways of eating (Ahmed et al., 1994; McCourt & Waller, 1996; Mustafa et al., 2016). The psychological and socio-cultural mechanisms driving the development of disordered eating based on the cultural conflict theory are not fully understood, however, there is enough research to suggest that there are culturally specific factors that influence eating disorders more so than acculturation to Western culture (Ahmed et al., 1994; Hill & Bhatti, 1993; McCourt & Waller,

1996; Mujtaba & Furnham, 2001; Mumford et al. 1991; Mustafa et al., 2016; Reddy & Crowther, 2007).

2.3.2 Parental Control and Cultural Conflict Over South Asian Women's Autonomy

Intra-familial and intercultural conflicts have been explored in the psychology and health literature as a source of psychological instability leading to eating disorders for some young South Asian women (Ahmed et al., 1994; Furnham & Adam-Saib, 2001; Hill & Bhatti, 1993; McCourt & Waller, 1996; Mumford et al. 1991; Mustafa et al., 2016; Reddy & Crowther, 2007; Varghese & Jenkins, 2009). In South Asian families with traditional values, conflicts arise between parents and their children over disagreements regarding their attitudes towards traditional versus Western values (McCourt & Waller, 1996; Varghese & Jenkins, 2009). For instance, on the topic of dating, traditionally South Asian parents have arranged marriages for their children and do not condone dating. However, in Western culture dating is the convention before two people decide to marry, which is viewed negatively by traditional South Asian parents because they believe males and females should not be involved in romantic relationships if they are not married (Hill & Bhatti, 1993; Mustafa et al., 2016; Varghese & Jenkins, 2009).

Given this, aspects of contemporary dating practices, which are influenced by both Western and traditional South Asian values, can be a source of stress or contention between children and their families. The pressures of living with two cultural identities that are sometimes conflicting can cause great internal conflict for young South Asians, particularly females, as there tends to be greater rigidity in granting autonomy for young South Asian women as a way of protecting females. It is believed that young South Asian women are at greater risk for problematic eating behaviours when they experience intra-familial and intercultural conflict, as they use their bodies as a way of gaining control over some aspect of their life that their parents cannot control rather than addressing their issues directly with their parents (Ahmed et al., 1994;

Hill & Bhatti, 1993; McCourt & Waller, 1996; Mustafa et al., 2016; Varghese & Jenkins, 2009). Internalization of stress and conflict, and issues with parental control are thought to cause psychological distress leading to the manifestation of eating disorders in some young South Asian women (Ahmed et al., 1994; Furnham & Adam-Saib, 2001; Hill & Bhatti, 1993; McCourt & Waller, 1996; Mujtaba & Furnham, 2001; Mumford et al. 1991; Reddy & Crowther, 2007).

The issue of parental control has been further explored as a contributing factor to the development of disordered eating behaviours in young South Asian women. “Parental control refers to the influence and impact of parents on their children’s choices in friends, activities, and romantic relationships” (Reddy & Crowther, 2007, p.52). For example, parents might demand that their daughter only have female friends, enforce early curfews, and insist that they have an arranged marriage. Conflicts arise between parents and children when parents attempt to control situations by restricting their children’s freedom to engage in behaviours that go against traditional South Asian values (Mujtaba & Furnham, 2001). The degree of control that parents enforce can lead to several psychosocial issues for children, including feeling socially isolated, like an outsider compared to their peers, and a loss of control over certain aspects of one’s life (Ahmed et al., 1994; Mujtaba & Furnham, 2001).

As mentioned earlier, the different degrees to which children and parents are acculturated is a source of conflict that has been linked to the development of eating disorders in South Asian women (Furnham & Adam-Saib, 2001; Hill & Bhatti, 1993; McCourt & Waller, 1996; Mujtaba & Furnham, 2001; Mumford et al. 1991). However, these studies have found that eating disorders have less to do with the adoption of Western values and more to do with the clash of attitudes of children and parents regarding Western ideas and traditional norms (Ahmed et al., 1994; Furnham & Adam-Saib, 2001; Hill & Bhatti, 1993; McCourt & Waller, 1996; Mumford et al. 1991; Mustafa et al., 2016; Reddy & Crowther, 2007; Varghese & Jenkins, 2009). For example, young women and girls might feel their parents should be more receptive to Western

norms of dating and allow them to date and choose their husbands rather than conforming to arranged marriages. However, as parents become more familiar with Western norms of dating and learn about the dynamics of dating relationships, such as the intimate and sexual nature of dating relationships, parents' attitudes may become more restrictive and level of overprotection may increase (Furnham & Adam-Saib, 2001). Mujtaba and Furnham (2001) found that among Pakistani girls, the amount of perceived parental control and overprotection was associated with higher levels of conflict within the family. For young women and girls with high levels of conflict associated with overprotection from parents there is a desire for greater internal control, in which females feel a sense of being in control over some aspect of their life that is not controlled by parents (McCourt & Waller, 1996). Thus, the need for internal control is manifested into eating disorders when females attempt to gain control over their own bodies through their eating behaviours. Several studies have cited internal control resulting from familial conflict as a large contributing factor to the development of eating disorders among South Asian women, however, the psychological and socio-cultural processes that are involved in leading to eating disorders are not fully understood (Ahmed et al., 1994; Furnham & Adam-Saib, 2001; Hill & Bhatti, 1993; McCourt & Waller, 1996; Mumford et al. 1991; Mustafa et al., 2016; Reddy & Crowther, 2007; Varghese & Jenkins, 2009).

2.4 CONCLUSION

A review of the research on eating disorders in South Asian women highlights the complex interconnected social and cultural factors that contribute to women's increased risk of developing eating disorders. Some of the prominent themes that emerged from the literature in the fields of sociology, psychology and health sciences demonstrate that gender roles and expectations, such as arranged marriage, acculturation to Western values and traditions, cultural conflict, and struggles with gaining internal control demonstrate the impact that these complex aspects of South Asian women's experiences' has on their elevated risk for developing problematic eating

behaviours (Anand & Cochrane, 2005; Hill & Bhatti, 1993; Kennedy et al., 2004, Khandewal et al., 1995; McCourt & Waller, 1996; Mumford et al., 1991; Reddy & Crowther, 2007).

Contemporary ways of living and cultural traditions, including practices like arranged marriage, are complex gendered forms of control regarding body image for women and girls, and produce particular kinds of eating, health, and body-related experiences among young South Asian women. The pressure placed on women to attain physical appearances that coincide with socio-cultural ideologies of beauty for the purpose of having a financially and socially prosperous marriage is one avenue that perpetuates the manifestation of problematic body surveillance measures, such as restrictive eating. However, in South Asian culture, food is used a symbol of love and gratitude, therefore refusing food presented to them would be considered disrespectful, but can also hinder one's goals for maintaining their body weight. Situations such as this can invoke a great deal of tension for women that are struggling with trying to attain cultural body ideals while upholding cultural values.

South Asian women also experience tensions that are not directly related to body surveillance, body image, food and eating, as research exploring cultural conflict has begun to explore. Struggles with internal conflict and lack of control underlie South Asian women's risk for developing eating disorders as explained by cultural-change theory. The highly complex interactions between South Asian women and their environment, namely Western society, invokes tensions with trying to balance two, sometimes conflicting sets of cultural values, while trying to create an identity for themselves. The struggle with creating an identity among others with conflicting values can be difficult, and it is thought that women internalize this struggle by manifesting psychological tensions by gaining control of an aspect of their lives, which sometimes leads to controlling their bodies and appearances, and can put them at greater risk for developing an eating disorder.

Chapter 3 - Methods

3 INTRODUCTION

Qualitative research is an exploratory method designed to examine behavioural, cultural, and social phenomena and gain an understanding of how people experience the world around them. It helps address questions about how or why certain phenomena occur and is intended to help gather rich data that can be contextually analyzed. Analysis of qualitative data often involves inductive approaches that build on existing concepts or theories of a particular experience or phenomenon. As much of the existing research on eating disorders in South Asian women has been approached using quantitative methods, my qualitative insights can help round out our current understanding how eating disorders are experienced in South Asian women.

“Inductive approaches are a hallmark of qualitative research and grounded in the social processes that people engage in and the meanings that they create from their experiences” (Carpenter & Suto, 2008, p. 26). Inductive processes involve making specific observations about a phenomenon or population, among which patterns of behaviour and/or social processes are examined to generate new knowledge or refine existing understandings (Carpenter & Suto, 2008). Qualitative research is exploratory in nature and well-suited for uncovering complexities about the social world people live and experience, and as such it can help “answer questions that ask what particular experiences are like and how people create meaning from their circumstances” (Carpenter & Suto, 2008, p. 21). In qualitative research, a relationship between the participant and researcher develops given the close nature of the data collection processes, which can consist of one-on-one interviews or field observations that involve intimate access to details of one’s personal life experiences over prolonged periods of time (Finlay, 2006). The benefit of gaining intimate access is the production of complex and rich data that provide broad as well as in-depth information about peoples lived experiences, an important step towards

understanding our social world (Finlay, 2006). Through qualitative techniques, the researcher has the ability to uncover taken-for-granted assumptions and meanings about social processes and phenomena by gathering data from those who experience the phenomena firsthand, and acquiring an understanding of the context within which a phenomenon occurs (Finlay, 2006).

Since there is limited research on eating disorders in South Asian women in general, and that which does exist tends to be quantitative in nature, there is much to be gained by examining disordered eating behaviours and the factors that shape this phenomenon through a focused exploration of their lived experiences. A better understanding of the meanings women attach to their experiences helps us understand why they engage in abnormal eating behaviours and what or how we might intervene to better support them in these difficult embodied and psycho-social struggles.

3.1 Narrative Inquiry

Narratives are a type of qualitative research that involves hearing stories from research participants about a particular event or an extended story about a particular aspect of their life, or about their life as a whole. I chose this methodology because it allowed me, as the researcher, to hear the women discuss their experiences and perceptions of how social, cultural and gender influences impacted their body and eating behaviours. Much of the epidemiological research on eating disorders in South Asian populations consist of data derived from questionnaires, structured surveys or scaling instruments, with analyses focusing on quantifying the experiences of participants to identify risk factors and analyze eating attitudes to identify correlations underlying the inflated prevalence of eating disorders in South Asian women. While this type of data is effective at identifying themes that correlate risk factors to higher prevalence rates in this population, qualitative analyses, particularly narrative inquiry, can enhance our understanding of why and how the identified risk factors contribute the manifestation of eating disorders in South Asian women.

The narrative approach highlights the importance of the telling of lived experiences and the attention paid to the different ways participants tell their stories. In my study, how the women told stories was of significant interest because the language they use, the sequence in which they discussed events, and the people/players in their life story are telling of how their experiences shaped the way they experienced the world, and more specifically how they experienced eating disorders. Being attentive to these discursive issues also helped me to identify how their disordered eating experiences are connected to and informed by broader cultural and gendered forces in the women's familial and independent or personal lives. Conducting narrative interviews is an active process that engages the participants and often evokes emotions that are pertinent to understanding the participants' perspectives. I allowed the dialogue to be led by the participants so they could choose to share thoughts and perspectives that were meaningful to them. My role was to reconstruct and analyze their stories and piece together information to create meaning from their experiences. My primary aim was to not only capture the lived realities of the research participants as they relate to eating disorders, health, and socio-cultural factors, but to also challenge the taken-for-granted beliefs and assumptions regarding the experiences of South Asian women with eating disorders, such as the assumption that eating disorders are highly motivated by a fear of gaining weight as the *DSM-IV-TR* suggests, or overlooking the impact of cultural influences as a risk factor for developing an eating disorder (Doris et al., 2015).

3.2 Participants and Recruitment

Seven research subjects (n=7) were recruited for this study. Each subject was female, between the ages of 19 to 29 years old, and first-generation South Asian-Canadian. Only women over the age of 18 were chosen to participate in this study as they were of legal age to consent and would not require parental consent to participate. Given the sensitive nature of the topics being addressed, and the stigma attached to mental health issues and eating disorders in South Asian

culture, it was important to ensure that the women could anonymously participate and feel safe discussing their health issues with me (Mustafa et al., 2016; Keel, 2010). The cultures represented in the sample include East Indian, Pakistani and Sri Lankan. The sample size chosen was adequate for the time allotted and for the study's objective to gather information-rich data about the role of gender, culture and body perceptions of young South Asian women (Morse, 1994). I conducted two interviews with each participant to collect thick descriptive data, which allowed multiple themes to emerge. To ensure validity of the data I used member checking by asking the women to elaborate and provide clarification to their experiences during their second interviews.

The participants for this study were recruited through a mass email that was distributed to Western University students between the ages of 18 to 30 years old. The response to the recruitment email was overwhelming. I received approximately 60 email and telephone responses to the mass recruitment email which specified the inclusion criteria to participate (Appendix D). The inclusion criteria required participants to be women between the ages of 18 to 30 years old that were first generation South Asian-Canadian, either born in Canada or living in Canada the majority of their life, and be of Indian, Pakistani, Bangladeshi, or Sri Lankan descent, who have experienced abnormal patterns of eating at some point in their life. Respondents to the recruitment email were selected based on fitness to this criteria so only those that met the criteria and identified as having experienced struggles with eating behaviours were selected for interviews. Of the respondents that contacted me in with their interest to participate in the study, I selected the seven participants that self-reported that they were first-generation South Asian-Canadian, between the ages of 18 to 30, and expressed that they had experiences with disordered eating at some point in their life. If participants were not forthcoming with this information upon initial contact I followed up with them asking to provide more information on how they meet the inclusion criteria. Due to the high rate of respondents to the recruitment email, I decided to

increase the sample size from four to five participants to seven for the opportunity to explore the topic with greater breadth and ensure the study's rigor. Six of participants selected were Western University students who were residing in London, Ontario, but whose original place of residence was in another city in Ontario, Canada or India. One participant selected was from Toronto, Ontario with no affiliation with the university. This participant heard about the study through a friend that attended Western who received the mass recruitment email.

Five of the women selected to participate in this study were first-generation South Asian whose parents immigrated to Canada and were described as having more traditional South Asian cultural values, versus those whose parents have been highly acculturated to Western-Canadian culture and values. Two of the participants were first-generation South Asian in Canada attending post-secondary institutions in Canada, who grew up in India and whose parents still resided there. The purpose for selecting first-generation women is that they are likely to identify more with their native culture and have more experience with traditional aspects of the culture via their parents than women who have been raised with parents that hold more Western values and have a greater degree of separation from their native culture.

3.3 Data Collection

For this study I used one-on-one in-depth interviews to collect information about young South Asian women's experiences with eating disorders. The interview format allows the researcher and the research subject to engage in meaningful dialogue to discuss significant aspects and events in the narrator's life (Lieblich et al., 1998). The participants discussed their experiences within the context of their South Asian cultural and gender roles. I met with each participant for a face-to-face interview in a location of their choosing. The participants chose the setting in which to conduct the interview. This was done to let them choose a space in which they felt most comfortable. Due to the nature of the discussions and depth of personal information they would

be sharing, the meeting spaces were private and secluded, and most were located on Western University's campus.

Upon meeting the women for the first time, I introduced myself and engaged in light conversation to build a rapport. I initiated the conversations with the women as we walked together to our interview spot. I expressed my desire to get to know them by asking 'how are you doing today?' and following up with questions about where they were from, what they were studying, and about their aspirations after undergraduate studies. I shared with them the same information about myself. When we reached our interview spot I debriefed the participant regarding the topic of the study I was conducting, and reviewed the letter of information and informed consent agreement with them (Appendix A). Each participant was informed of their right to withdraw at any time, their right to decline a response, and they were made aware that they would be provided financial compensation in the amount of twenty Canadian dollars per interview for a maximum of two interviews for their time and travel expenses for participating. They were made aware that their interview would be voice recorded for data analysis purposes, however they were free to decline if they did not want to have their interviews audio recorded. None of the women declined having their interview audio recorded. All of the women were deemed to have the capacity to provide consent, and all were of legal consenting age. Everyone provided their consent to participate by signing the Informed Consent Agreement (Appendix A).

Following the obtainment of consent, I continued our conversation by asking them about their families and what it was like for them growing up, specifically what their relationship was like with their parents and siblings (if they had any). Some of the women asked the same questions of me and I offered a brief description of my experiences. It was important to engage in conversation about my relationship with my parents and siblings, as it was a way of strengthening our rapport and creating a comfortable space for them to speak openly and honestly. The interviews were guided toward specific aspects of their lives using semi-structured

questions to prompt the participants to discuss topics of interest (Appendix C). The interview guide was referenced to follow-up with questions detailing aspects of their family relationships, such as: “how would you describe the way your parents raised you?” Following the discussion about their family, questions regarding perspective on gender and culture were addressed, for instance, the participants were asked to explain some of the cultural expectations that South Asian females have within the family unit and outside of the home/family. More general questions about their views on culture and gender roles were addressed to ease into questions that were more specific to their personal experiences. This was a way of strengthening our rapport, so the women would feel more compelled to share their own stories. They would often offer personal anecdotes to these general questions to help explain their response, which allowed for a natural progression from the opening questions to more in-depth accounts of their personal experiences.

Next, specific questions addressing aspects of their lives that have influenced their disordered eating behaviours were asked. To lead into these discussions, I used a vignette to initiate the sensitive topic of discussion around eating disorders (Appendix D). The vignette was about a prominent South Asian female public figure, Nina Davuluri, former Miss America, who was a young South Asian woman who openly discussed her struggles with weight and body image. The participants were asked to provide their opinion on the scenario presented, however the vignette was minimally effective at engaging the participants in open-ended, subject-guided discussion, as many of them were unfamiliar with her story. For those who were unfamiliar with Nina Davuluri’s story, I provided them with a summary and followed up with questions regarding their impressions of the pressures women endure to be thin. The discussions around this were brief, and the participants mostly discussed that they felt that public figures endure greater pressures when it comes to body image than most women because of the nature of their careers in the public eye and the media’s preoccupation with body size so they could not relate to

the vignette personally. I proceeded on to ask the women about their feelings and perceptions of beauty and body image, and how their cultural identity influenced these complex aspects of their life. These questions elicited a great deal of rich data and participants shared anecdotes of their personal experiences and struggles with body image.

Finally, I initiated discussions about the participants' experiences with disorder eating with questions pertaining specifically to the role that food and eating has in relation to their cultural identity, and the impact it had on their eating patterns and behaviours. All but one of the participants were interviewed on two separate occasions. The participant from Toronto, Ontario was unable to coordinate an in-person follow-up interview due to challenges with scheduling a mutually agreeable time to meet. The participant requested an interview via online video conferencing, however due to the possibility of infringing on the protection of her privacy this was not possible. Each interview lasted between 90 to 120 minutes. The intention of a narrative inquiry is to allow the participant's story to be drawn out in their own words and choice of sequence of events (Lieblich et al., 1998). Probing questions/comments were used to elaborate on discussions and guide them to discuss their experiences in areas that were pertinent to the study, such as relationships, family dynamics, cultural experiences, and eating behaviours. The participants led the conversations by discussing the stories that they felt were most meaningful for them in shaping their perceptions and eating behaviours.

The data collection consisted of an iterative process that involved informant feedback as a method of ensuring reliability and validity of the data being collected. Once the data from the first interviews were reviewed, I presented the participants with follow-up questions in a second interview, which lasted approximately 60 to 90 minutes, to allow them to elaborate on thoughts or statements that they made in their first interview. This second interview was an invaluable way to gain further clarification on certain issues and it provided me with confirmation that I was interpreting their experiences accurately. The questions in the second interview were based on

the data from the first interview of each participant. I asked the women follow-up questions based on specific statement that they made in their first interview to gain a better understanding of their experiences and to ensure accurate interpretation of the data. The follow-up questions were specifically related to each participant's individual accounts of their experiences, therefore there was no interview guide used during the second interview. This allowed conversations to flow naturally so the women could describe their experiences in greater depth. For instance, when participants discussed experiences that affected their self-esteem, I asked them more questions related to the impact it had on their body image which led them to explain how they modified their bodies to gain confidence, specifically how they altered their eating habits to achieve a more idealized body shape/weight.

Following the collection of the data from the first and second interviews, I listened to and transcribed the participants' interviews. The audio-recorded interview data was manually transcribed by listening to the audio files and writing up the transcripts using Microsoft Word. The transcriptions amounted to approximately 400 pages of typed data that would be manually analyzed. The participants' real names were removed from the transcriptions and replaced with pseudonyms. All of the transcribed data files were then uploaded and stored on a personal computer, and the files were password protected to ensure the information remained secure. Backup files were saved on the online file storage website, Dropbox, which was also password protected.

3.4 Data Analysis

Qualitative data analysis involves an in-depth review of the textual data collected, and is examined in segments to identify patterns and themes that emerge in the data. A commonly used approach in qualitative data analysis involves coding segments of the text and organizing similar patterns into categories to uncover broader themes. In this study I used a line-by-line approach to review the transcribed interview data in-depth, which allowed me to identify the major themes of

beauty, body image, and health that emerged from the women's discussions about the meanings that they attributed to their experiences with disordered eating. The women's stories provided insight into social and cultural circumstances that influenced their behaviours in relation to the prior literature on eating disorders in South Asian women.

The process of analysis began by transcribing the interviews verbatim from audio to text. A content analysis of the data was performed manually by coding, categorizing, and identifying emerging themes from the data. I analyzed each participant's interview transcript manually through a process of line-by-line thematic coding to uncover various domains of experiences that were common across similar characteristics. This process was initiated by coding the transcripts line-by-line and assigning labels to segments of data to capture the essence of the topic and issues the participant was discussing. Next, the labels were grouped to encompass similar labels into broader categories that represented the main ideas presented in the data. These categories were then further condensed to uncover the major themes that emerged from the data. For ease of organization of the data I created place cards for each code, category and theme to visually examine the codes and to ensure they were placed in appropriately placed. Codes that did not fit any of the categories that had emerged meant a new category was required. This process continued until the data was amalgamated to the point where no new categories emerged. These categories highlighted the broader themes that emerged from the data, and these broad themes lead to unveiling the major themes. The themes that were most recurrent throughout discussions among the participants were grouped into the following categories: beauty, self-esteem, body surveillance, familial influences on eating behaviours and health.

The interpretation of the data required an iterative process of listening to the stories and examining them more generally, and focusing on how the women spoke and positioned themselves within the story, which provided valuable information about how they perceived themselves within the context of their cultural and social experiences, and helped to understand

how they gave meaning to their experiences. Understanding their experiences was fundamental to the interpretation of the women's stories to understand the complex dynamics of their relationships, and interactions with their environments, that consisted of a duality between Western and South Asian cultural influences.

3.5 Quality Criteria

To ensure quality and trustworthiness in qualitative research, Morrow (2005) discusses the practice of reflexivity to ensure authenticity of the research. Reflexivity is a process of being self-aware of one's biases and assumptions and it is also a practice that makes space for the researcher to record her experiences during the research, which is a complex and difficult journey (Morrow, 2005). I kept a reflexive journal to record my thoughts, experiences, and reactions throughout the research process. The journal was effective for recording notes I made during the interactions with the participants during the interviews and in "off-the-record" interactions, such as initial meetings or directly after the interviews. This also helped to ensure transparency and quality of the data. Additional items recorded in the journal include the participants' response to the project. It was very rewarding and encouraging to know that they were comfortable speaking with me about their struggles with their body image, which was something they did not openly discuss with anyone. As I reflected on why the women felt this way my initial impression was that as a South Asian female myself, they may have felt as though I could relate to or understand some of the complex contentions they experienced in their relationships and in balancing two cultural identities and some of the gendered constraints that structure women's lives in South Asian settings in particular ways compared to those of men.

3.6 Ethical Considerations

Ethics approval to conduct this study was obtained through Western University's Non-Medical Research Ethics Full Review Board prior to data collection. All of my participants were required to provide free and informed consent prior to participations in the study, meaning that their

consent was voluntary and free from coercion or undue influence to participate. The participants were provided full disclosure of information in order to make an informed decision about being involved with the study (Smythe & Murray, 2000). They were informed that they were free to opt out of the study anytime, and they were not obligated to share any information that they were not comfortable sharing. Informed consent was obtained prior to conducting each interview to ensure consent was explicit throughout the research process (Smythe & Murray, 2000). All participants consented to participating and having their interviews audio recorded for data collection purposes, and they all voluntarily signed a consent agreement as written confirmation of consent to participate.

Due to the potentially sensitive nature of the topics discussed, it was necessary to ensure privacy and confidentiality to protect the rights of the participants (Smythe & Murray, 2000). This study required participants to disclose personal information about their culture, age, religion, and other identifying data. Participants were informed about disclosure of personal information and consent was obtained to use the information for data analysis purposes. Identifying information has been removed from the data and replaced with pseudonyms to ensure protection of the participants' identity and privacy.

It is the participant's right to be free from harm when participating in a research study (Smythe & Murray, 2000). Although risks in this study were minimal, the potential risks involved provoking emotional distress due to the sensitivity of the information being discussed. Prior to commencing the interviews, the participants were made aware of the potential risks of being triggered or experiencing emotional distress during our discussions. None of my participants appeared to have experienced significant emotional distress during the interviews, nor did they express that they wanted to stop the interview process, however, I am cognizant that the sensitive issues discussed may have been difficult for my participants, even as they expressed a desire to talk about them with me. In the event that a participant expressed they were struggling

with emotional triggers as result of discussing their experiences, or if they requested the interview be stopped, I had information about local mental health and eating disorder resources and services on hand to make available to them. The women were also informed that they could contact me at any point, should they need or want, after the interviews have taken place to inquire about additional resources or community supports. To avoid doing harm to the participants during the process by misinterpreting of their stories, it was important to engage them during the data interpretation process by following up with clarification questions to ensure that narrations were being interpreted accurately as it was intended by the participant. This allowed the participants the opportunity to clarify areas of uncertainty or misinterpretation, or withdraw information they had shared. This process of clarifying information with the research participant is known as member checking, and was performed in a second interview with participants.

3.7 CONCLUSION

This chapter provides an overview of the purpose and value of qualitative research as it applies to examining eating disorders in South Asian women, and describes the process of narrative inquiry as semi-structured approach to gathering information about the lived experiences of women of a particularly vulnerable subpopulation that are at greater risk for developing eating disorders. The data collection and analyses highlight the efficacy of the narrative approach for this particular study, as it encompasses a semi-structured format of collecting the stories of particular interest for this topic, but allows the participants to guide the conversations in a personally meaningful way within the context of their cultural and gender identity. The next chapter provides an overview of the current literature as it relates to this study's findings.

Chapter 4 - Findings

4 BEAUTY, BODY IMAGE AND HEALTH

4.1 INTRODUCTION

One of the primary findings of this study is that beauty and body image are deeply intertwined and understood in relation to physical appearance and ideals that are shaped by South Asian and Western cultural influences. My participants often discussed these influences as competing sets of ideals that were internalized in complicated ways, and they also produced significant challenges or tensions regarding how they felt about themselves as they were figuring out how to live up to or resist them. The study findings also demonstrate how ideas about beauty and body image are shaped by social and individual-level factors, and are bound up with the ways in which young South Asian women think about and experience their health. Indeed, discussions about beauty and body image, including the themes of hair, skin tone, body shape, weight, and dieting, often led into discussions about how they perceive their own health. Health in this context includes mental and physical health and is a complex issue that the women discussed in interesting, and powerful ways, through reference to eating habits, relationships to food, and various cultural and familial influences. This chapter explores these data, with a particular focus on how my study participants understand and experience the inter-related issues of beauty, body image, and health.

As discussed in the previous chapter, these findings emerged as the most prominent themes related to my study questions and were the topics that the participants spoke about most often during the interviews. Within each theme the participants discussed additional topics or experiences that emerged as sub-themes. Regarding beauty, the women talked about the primary features that define and encompass cultural ideals of beauty and their significance within the

South Asian cultural context, both of which are unpacked below. With respect to body image, the women spoke at length about the powerful role played by socio-familial influences, namely family and peers, in the construction of their ideas about their bodies and themselves. They also identified how the critiques or comments from these social players fed into or exacerbated the various techniques of self-surveillance they employed to maintain their desired body image. Regarding health, the women revealed how they navigated competing cultural influences and desires regarding body and health-related ideals, which were shaped by socio-cultural and familial forces and had a significant impact on their eating behaviours and struggles.

4.2 BEAUTY

4.2.1 Definitions and Key Elements of Beauty

The ideals of beauty identified among the participants were remarkably consistent and they centred around particular physical characteristics, specifically being tall, being thin, having thick hair, and possessing fair or ‘light’ skin. All of the women felt that they did not meet these criteria and many described themselves as being “not pretty”, despite possessing one or more of the characteristics in their definition of beauty. They often began their discussions of this issue with descriptions of the ideal defining features of beauty for South Asian women, as did Radha said:

I would say the ideal South Asian woman, she would be tall...light and skinny. And should have long black hair and it should be silky smooth. That’s how I’d think of South Asian women so I guess that’s the standard and that’s the expectation.

These ideals are echoed by Lola who described South Asian beauty in the following way: “ A good body and are thin, and you have long hair. That is one thing in Indian culture. Even if you are very traditional and you have short hair...everyone is like ‘you should have long hair.’” These characteristics that defined beauty were seen to be a significant aspect of gender roles for South

Asian women, as discussed in the next sub-section where the links between beauty and marriage are a focus.

4.2.2 Cultural Significance of Beauty and Marriage

The beauty ideals that the participants identified were discussed from the perspective of first generation South Asian-Canadian women who were of marriageable age, according to South Asian cultural norms. The primary social role most South Asian women are raised to achieve is that of wife and acquiring other traditional female duties that inform this most important of gendered roles are also central to their socialization, including familial and caregiver duties. In the past and today in South Asian culture, the preferred form of marriage is that which is arranged and parents as well as other family members (and sometimes other community figures) take an active role in ‘matching’ young women and men. The degree to which these young people can influence the marital selection process is limited, particularly among women whose prime attribute in these proceedings is their beauty. It is in this context that my participants discussed the cultural significance of beauty. Here Maya explains how women are taught to strive for culturally-determined beauty ideals to ensure the best prospects for marriage:

You have to have the long, silky, thick hair...fair skin... light eyes...they almost feel like they’re forced to live up to an expectation that has been laid out for them in order to have a better future...it’s more like who am I going to get married to...that’s where the focus is.

This socio-cultural understanding that a woman’s prospects for marriage are closely intertwined with her prospects of having ‘a better future’ puts significant pressure on women to be beautiful. As Sara discussed, women are primarily judged on their beauty during the mate-selection process and that is where the emphasis is focused in determining if a woman is a suitable wife and daughter-in-law:

There are people that are very very concerned about beauty because someone has to choose a daughter-in-law for themselves, and beauty is the first thing they want to see...Normally girls try to reduce their extra pounds while they are getting married...if she's not very good looking then its understandable that she has to make a compromise in terms of the looks of the spouse she will have.

From her perspective, women need to make themselves more physically attractive to increase their chances of being chosen to marry into a family with higher social status. She also points out that there may be inherent physical traits that a woman cannot easily change about herself. In these cases, a woman would need to accept the reality that she will not achieve the high status and will likely have to settle for someone of lower socio-economic status and/or who is not physically attractive.

The socio-cultural values linking beauty to marriage, which are also often intimately connected with women's quality of life, are common associations made within South Asian cultural settings. These standards and associations are reproduced in the advertisements placed by families in local and international papers that are designed to secure men and women with specific physical traits, to begin the marital matching process or "alliances" as they are sometimes referred. As Lola described, these advertisements feature the same modal characteristics that she and the other participants have identified as encompassing South Asian ideals of beauty: "For the marriage alliances some of them will advertise like 'seeking slim, tall, fair, beautiful girl,' so they don't care what the girl has, you know, achieved in her career path." The printed advertisements seeking beautiful women for arranged marriages are more commonly seen in South Asian countries, however, the practice of seeking females for marriage through reference to the socio-cultural understanding of South Asian beauty ideals is prevalent among South Asian-Canadians as well.

The candidness within South Asian culture regarding beautiful women being more desirable creates an environment in which women are vulnerable to the exertion of social pressures to look a certain way, particularly because of the connections between beauty not for just its ‘own’ sake but as an avenue to marriage and familial status. Radha discussed the pressures she felt from her family to have fair skin to better her prospect for marriage, which prompted her to consider using bleaching creams to lighten her skin:

You have to get married, like that is the biggest thing, and you always have to be light.

After the summer I always get super dark and my grandma’s like ‘oh my god, how are you going to find a husband’...it’s a pretty big thing, like you know like everyone uses [*fair and lovely*¹] and stuff...”

4.3 BODY IMAGE

4.3.1 Socio-cultural Commentary

Some of the most compelling insights about beauty and body image emerged in the participants’ discussions about the social contexts in which they were exposed to negative commentary about women’s appearances, including their own. Overwhelmingly from women within their families and extended community groups, these comments function as a form of social control that not only served to remind the women of how or if they measured up to beauty ideals. This often led to the internalization of feelings of inadequacy about their appearance, their bodies, and their social value as women; it also generated a great deal of pressure to engage in body-surveillance techniques to achieve socially determined ideals of beauty and avoid critical commentary about their appearance.

My participants observed having many of these experiences while attending family or social gatherings, often highlighting their frustration with how ‘accepted’ or normalizing passing such judgement on women- often by other women- is within the South Asian setting, especially

¹ One of the most popular skin ‘lightening’ creams in South Asia.

about appearance as it pertains to body weight or shape. Sundari described memories from her childhood when she attended dinner parties with her family and would overhear family-friends making comments to her mother about her weight, which she identifies as the point in her life was when she realized how much her appearance was being judged by those around her. This had a tremendously negative impact on her body image and feelings about herself:

When I was younger and chubby...I would eat so much at family get-togethers...they would sort of tell my mom...she's eating a little too much and you should tell her to sort of watch her portions....So ever since then I became extremely self-conscious about how much I ate, and how much I ate in front of other people...then I sort of realized this creation of this sort of public identity and private identity.

For Lola, it was an interaction with her South Asian friends at a social gathering that was a defining moment for her that triggered her negative body image and body-surveillance efforts. Here she describes how she had gained some weight since she last saw her friends, who were quick to let her know that they noticed:

I still remember going for my undergrad convocation and my friends made fun of me like 'oh my god, what have you done to yourself...you're so fat now'...Like how many people would really compliment you when you lose weight...but like if you get fat its like so many people will tell you.

The women's keen awareness that body image, and their self-identity, are intimately bound up with others' perceptions was a difficult realization to learn and it is something that continued to exert considerable force within their lives and for many fuelled a lifelong struggle with negative self/body image. This is reflected here, where Radha describes the tone of these comments and draws our attention to how hurtful these comments are: "You're [either] too skinny or too fat...if you put on weight everyone's like 'you put on weight'...the way they say it, like their tone is

like ‘no you don’t look good.’” As a result of these ‘accepted’ cultural assaults on her physical appearance she began to dread the prospect of attending social events because someone might make a comment to her about her weight, which would make her feel very unhappy with her body:

I always hate going to those family functions because I know someone’s going to say something like, usually I know its not supposed to affect you but it always does... I had to wear a sari for [my sister’s] function...a lot of people could be like ‘oh you look pretty’ and this one person can be like ‘oh you look like you’ve gained a lot of weight,’ and I’ll be like ‘oh my god, now I have to lose weight.’

The overwhelmingly critical comments made to the women about their weight made them incredibly self-conscious and dissatisfied with their bodies. They described how this, in turn, set in motion a process of strict monitoring of their bodies and engaging in behaviours to lose weight because of the comments they heard. As Radha explained:

When I was younger and someone was like ‘you’ve gained weight’, I’m like ‘oh my god I have to lose weight now.’ And then like after that, even if people didn’t tell me [to] I’d try to lose weight...I would just base it on what people would say like ‘oh, you lost weight,’ or like, ‘oh you didn’t’...”I’m like ‘what do I do to please you guys’, no one is ever satisfied with my weight so that’s always been an issue...I would say it’s like a big influence because I still struggle with it.

Several participants noted that negative comments from others about weight-gain would provoke body dissatisfaction and dieting behaviours, however, comments about weight-loss boosted their self-confidence and body satisfaction and made them feel socially validated. Indeed, this was identified as a driving force behind some of their weight loss behaviours , as Sundari said: “I wanted to hear that you were working out too much. I wanted to hear ‘you’re

becoming a little bit too thin' because it gave me a sense of fulfilment. It gave me a sense of 'you're achieving this goal.'" Lakshmi expressed the same sentiments regarding comments she received from others about being "skinny", which she experienced as validating and used to justify the achievement of her body ideals- even though some of them were unrealistic and unhealthy. She discussed an interaction where someone made a comment about her weight that was intended to express concern for her health, but she interpreted it as a compliment and which boosted her body satisfaction: "One of my teachers was like 'you're one of the skinniest girls I've ever seen,' and I was like 'yay to me!', and I just never thought anything of it."

The normalized and commonplace nature of passing comments about women's appearance within the South Asian context my participants live in significantly affects their body image and their health, often very negatively through the development of various techniques of body surveillance measure they use to achieve what has been constructed as the ideal body image. Padma framed the tendency for South Asians to make critical comments to women about their appearance as problematic, especially when woman's health and well-being should be the focus of concern:

I think the problem with South Asian culture...women especially...feel like they have the right to make comments about your body. Like it's different if they're trying to help you or trying to show you the better way of like having a healthy lifestyle, but most of the people are making comments about your looks.

One of Padma's experiences involved feeling insecure about her body because of comments made to her by her South Asian, female, family physician. She explained that her doctor told her she should consider trying to lose weight shortly after giving birth, which made her feel very self-conscious about and unhappy with her body. It also raised concerns for her because it was

being conveyed to her by a health professional, whom she thought would be more concerned for her health and well-being as a new mother versus her body size:

The doctor was like...you should consider moderate exercise to lose weight'...I went to a Tamil doctor [and] it just made it like oh my gosh, I should lose my weight...I think when you're like skinny before and you have a child people expect you to be the same weight after you have a child, even though they know your body changes, they still want you to look the way you did in the past.

This example also illuminates how pervasive these 'commentaries' are about women's body shape and size within the South Asian cultural contexts my study participants inhabit in their daily lives, which can extend beyond the harsh glare of family and friends into the realm of the professional/ places within which their health depends.

4.3.2 Individual Management and Surveillance of the Body

The data presented in the previous section reflected how the participants used comments from others to assess their bodies and determine their body surveillance measures accordingly. They used social commentary engrained in cultural ideals of body and weight to gauge their satisfaction with their bodies and modify their behaviours based on their interpretations of how others view them. While some participants tracked their weight on a scale, many used non-quantifiable markers to assess their weight gain or loss. These included assessing their body in a mirror and observing how well their clothes fit or any physical changes to the shape of their body, particularly the amount of body fat they had. These measures could engender less severe monitoring of their body size/shape/appearance, compared to the extreme obsession with their bodies and losing weight that many discussed experiencing when trying to achieve a specific number on the scale. Radha explained how she felt weighing herself on a scale exacerbated her problematic eating behaviours and drove her unhealthy focus on attempting to achieve a specific goal weight: "I never weighed myself. I felt if I weighed myself I would have to meet a certain

number. I never did that which I'm kind of glad I didn't do that because if I did that it could have been worse, like if I just weighed myself everyday." Maya also discussed not focusing on the scale to monitor her body, preferring the assessment of how she fit into a favourite pair of jeans to determine if she had gained or lost weight:

My mentality was never like 'okay, you need to lose a set number of pounds'...it's like I just want to fit into these jeans...I would change my habits, whatever I would [have to] do to fit back into these jeans, that's how I knew like 'okay, its fine now, now I can go back to eating how I want to.'

Some described how they would compare their body shape to others their friends or even themselves at a previous point in time by, for instance, comparing old pictures of themselves to current ones. In her interview, Sundari discussed comparing her present body against her teenager body, adding that she would identify specific areas that she wants to change in order return to her remembered, younger body. This approach at self-perception and embodied knowledge did not provide realistic or tangible markers with which to assess her body goals, dependent as they were on a constructed or idealized body of the past. As she notes below, employing these intangible benchmarks increased her body dissatisfaction:

Like I'm always monitoring everything and I'm always dissecting everything, and always comparing myself to the past. So in my eyes I was at the peak of my physical fitness or whatever, at the end of high school, where I was as thin as I had ever been...I just praised that girl and I would long for that girl because she was so physically where I want to be, and now I'll compare myself and see that I need less fat here and less fat here.

The participants highlighted the important reasons that they felt measuring their weight objectively or via standard approaches like using a scale was problematic for their body image

and body surveillance. However, the data clearly demonstrate that the indeterminate measures they used along with the comments from others produced their own variety of negative outcomes regarding how they felt about their appearance and the weight management strategies they used. These complex forces contributed to their problematic and unhealthy eating behaviours and their conceptions of health, as discussed next.

4.4 HEALTH

In the previous sections I explored the primary sociocultural experiences of my participants that have shaped their self-perceptions, esteem and embodied behaviours. Here, I examine how family and social interactions impact the participants' ideas about health, which was primarily expressed via ideas about food and eating. The links between these issues and physical, as well as mental, health were also mentioned frequently by the participants and are discussed below.

The experiences related to unrealistic beauty ideals and the different forms of critique used by others to assess the women's appearance led many of them to engage in unusual or disordered eating behaviours, which were different for each participant. The most common strategy discussed was to manage their weight through calorie restriction, which took the form of skipping meals; avoiding certain types of foods, such as carbohydrates; manipulating portion sizes by using small utensils and plates; and counting calories. Their experiences shared during our interviews clearly illustrate how very conscious the women are of their eating behaviours, which they engage in to manage not just their weight but also their body shape. For some, as discussed below, these behaviours had a significant impact on their health and lead to clinical diagnoses of conditions like anorexia nervosa and diabetes mellitus.

4.4.1 Social and Familial Influences on Health and Eating Behaviours

Participants often spoke about their weight, food, and health through reference to the ways in which their family members perceived and talked about these issues. For a number of participants' their fathers were the primary source of information and motivation related to body weight and eating healthy, which was linked with their desire to prevent conditions like diabetes, hyperlipidemia, and heart disease. From my reading of the data, their fathers were dominant authoritative figures in their families, which may have impacted why the women aligned their views on health with those that their fathers endorsed. In some cases, the women internalized these concepts through an embodied lens that focused on the social value of losing weight over the concept of maintaining overall health. This internalization is also informed by the clash between Western and South Asian ideas about health as well as eating, with the former focusing more on health and the latter more on body size or thinness.

For Lakshmi, her father's concerns about his own health began after he was diagnosed with high cholesterol. At this time he was motivated to change his lifestyle to manage his condition and started to exercise and adhered to a strict diet which he also enforced on his family:

[My dad] had high cholesterol or something, and the doctor was like okay you need to manage your cholesterol, so he went on a crazy health fix. Like he would exercise all the time, and he was super strict on food for us, and he dropped so much weight that the doctor was like you need to stop...so for a long time in my house we would never have any junk food. Like a granola bar was considered out of the question...so growing up there was like this certain culture around food that it was sort of this restricted thing for a while...it meant something different to me than it probably did to any other kid.

Her father's intentions of promoting healthy eating led to Lakshmi developing a negative relationship with food and eating. She viewed it as something that needed to be restricted or

avoided. Growing up learning these ideas about food and eating directly impacted her negative associations with food, which became an engrained norm and significant struggle in her life from her earlier years up until the present-day. It could be seen as ironic that her father's good-intentioned attempt to promote healthy habits resulted in Lakshmi developing a skewed perspective about 'healthy eating' and profoundly impacted her development of anorexia. This example also illuminates some of the devastating, albeit unintended, outcomes that intense judgement and body surveillance can have on shaping the values and norms placed on women in South Asian settings.

Comments made by family members can have a strong influence on the way we think and feel about our bodies, whether judgements are made overtly or implied. In the case of Maya, her older sister had qualms regarding her own weight and frequently mentioned losing weight, which led Maya feeling insecure about herself:

My sister, she's constantly, constantly commenting on her own weight and my own weight and it's in subtle ways that I don't even think she realizes...she'll say something like 'oh this doesn't fit me so it probably fits you,' like you know bigger...and still now I'll go home and the first thing she does is like 'does it look like I've lost weight?'

This constant focus on weight contributed to her feeling as though she needed to be careful about the types and quantity of food she ate, and it made her feel self-conscious about what she ate and how she ate around others: "I normally didn't eat lunch and that threw people off because they thought there was something wrong. I just was not hungry like I don't want to eat lunch and also felt very uncomfortable with the idea of people watching me eat."

Beyond growing up with familial messages about restricting her food intake, Maya also experienced contradictory familial influences regarding weight control that encouraged eating plentifully. She explained that her tendency to overeat was influenced by cultural customs that

use food as a symbol of courtesy and generosity, and accepting an offering of food felt obligatory for her to show respect for the hosts' hospitality. She described how meal time at home would also result in overeating because her mother made sure that she was well-fed and emphasized the importance of not wasting food, particularly because her family in Pakistan live in impoverished regions where food is rationed due to high costs and scarce availability:

Growing up our mom would spoon out our food for us, and like one isn't enough so she'd put two or three...you knew you had to finish the food that was on your plate because then you'd be wasting food, and there's this engrained thought that...food cannot be wasted because there's so many people in the world that don't have food, and even in parts of the world where your extended family lives, they don't get to enjoy the same kind of meals that you do.

4.4.2 Dieting and Restrictive Eating Behaviours

Many participants began some form of dieting at an early age and were still engaged in these behaviours at the time of the study interviews. The word “dieting” was used to describe some of the unusual patterns of behaviour that they engaged in as a means of losing weight and achieving a thinner body physique. For instance, some women resorted to binge-restrict eating patterns which are characteristic of eating disorders. Others adopted “special diets” such as gluten-free diets, carbohydrate-free diets, vegetarianism or veganism to restrict their intake and lose weight. Others selectively chose when they would engage in dieting behaviours and would, for instance, begin a diet prior attending family events or social gatherings when they knew they would be subjected to others’ scrutiny about their appearance. Still other participants used the word ‘dieting’ to describe patterns of eating behaviours that are not typically associated with what most people would consider healthy dieting, such as skipping meals, or counting calories to limit their intake.

Lola adopted a pattern of restrictive eating which eventually led to a diagnosis of type-2 diabetes. She would eat only one meal a day, which consisted of five hundred calories which was consumed for her dinner meal. In her interview she talked about feeling insecure when she was in social situations where people were consuming less healthy foods, like pizza, so she would limit the amount of food she would eat or completely avoid eating the less healthy foods because of her insecurities about her weight. She would also exercise excessively to compensate for consuming extra calories. She believed her behaviours were an effective approach to lose weight until her body was not able to sustain her unhealthy eating patterns, and now she is forced to learn to eat regularly and make healthy foods choices because of her diabetes diagnosis:

At one point I was having like zero breakfast, skipping lunches and just having dinner...I have continued this for like 7 months...I felt like I was strong enough to handle all that fasting...I can lose weight quick, but in this way I think I really messed it up with my body.

Radha adopted a similar pattern of eating where she would not eat breakfast and sometimes lunch, and would have her first meal of the day in the evening. She also avoided foods that she felt were too fatty and might cause her to gain weight:

I wouldn't eat breakfast and sometimes I wouldn't eat lunch. So I would come home around 3:30 and that's when I would have the first meal of my day. That was really bad but I did that for the longest time... I wouldn't eat certain things, like I would not eat rice, or I would eat very little rice... so I would be like 'oh, if I eat more rice I'll just get fat.'

For Sundari, rather limiting her caloric intake or the number of meals she had in a day, she eliminated foods from her diet that had higher fat content, such as animal products, to limit as much "fatty" foods from her diet. She decided to adapt a vegan diet because it was a choice her

father made for personal health reasons, but she noticed he lost weight on the vegan diet and it would be possible for herself to do the same. Her family was critical of her dieting for weight-loss, so she adopted the vegan diet and framed her diet choice as health-conscious decision. She felt that the diet that would help lose a lot of weight and also be supported by her family:

I cut carbs and then there was a point when I was vegan. I cut carbs then eggs, milk, meat...it was acceptable because my dad went vegan a couple of years ago for diabetes, so I was like 'dad I'm just doing what you're doing, I'm going vegan,' because I saw how much weight he lost...And when we would talk to family and stuff like that he would say I went vegan and cut so much, and this is how much weight I lost. And there was this part of me that was like 'yo, I can do that too, right!'

Lakshmi raised another complex aspect of physical appearances among young South Asian women (and other women of colour), how race structures her behaviours, eating, and ideas about herself. She discussed her desire at a young age to look more like her "white" peers, a powerful factor that was shaped by the fact that she grew up in a primarily White community, which made her feel different and excluded based on her physical appearance. This had a profound effect on her body image and self-esteem. Her disordered eating behaviours early on in adolescence and were motivated by insecurities about her body as she reached puberty and experienced changes to her body shape. She compared herself to her peers who she described as "petite" and her desire to reduce her size to conform to them involved early onset dieting behaviours like cutting out certain foods. At one point, she restricted her consumption to 200 calories or less per day, which led to a drastic deterioration in her health and eventually landed her in inpatient care for anorexia. Lakshmi explains:

When I was around 12 I slowly started to like diet I guess. I was quite insecure about...I was more developed in the upper bust area...my body shape, and my build was

just different than my friends at the time who were very petite... and so I like started to sort of diet and I remember starting to cut out junk food and pop or whatever...like in total I might have had like 200 calories in a day, and bit of yogurt was like breakfast, and that's it.

4.4.3 Impact of Culture on Eating Behaviours

Cultural traditions related to patterns of eating and food also had an impact on the participants' eating behaviours. The participants described the South Asian diet as being higher in carbohydrates and oils than a North American diet because of the types of foods that are traditionally cooked. In South Asian culture many meals consist of starchy, high carbohydrate staples such as rice and roti (wheat flat breads), and main dishes are curries that are cooked with high quantity of ghee (clarified butter) or oils, and very few raw or fresh vegetables, whereas North American cuisine uses oils in smaller quantities and North American trends lean toward using 'healthy' fats such as olive oils or vegetable oils, and it is common to have raw vegetables in salads or lightly cooked (steamed or lightly fried) with meals. Radha explains what typical South Asian meals consist of: "...rice is always something we have for lunch, and dinner is like another kind of starch. Either we eat rotis or always some kind of bread, right, and then you always eat more of the rice. It's always rice and little bit of the curries..." Not only were the types of food that are traditionally eaten were viewed as unhealthy by participants, but the many traditional South Asian dishes were prepared in unhealthy ways. Sara describes the way South Asian food are usually prepared:

In my culture we eat high calorie food. We eat oil. Majority of our food items involve a lot of oil so our food is very oily and very spicy...We like call it sabji. Its vegetables...We fry them a little bit. The similar thing is done with whole-wheat stuff as well. We simply make a round roti and put some oil on it.

Some of the women suggested that because of the way South Asian foods are prepared that South Asian people were not very health conscious or concerned about making healthy food choices. They felt that growing up with the North American cultural influence encouraged them to think differently about what they ate, and therefore they made an effort to include a variety of food groups and limit the use of fats and oils in their diets in order to have more balanced and healthy meals. Lola describes how South Asian food is traditionally cooked in fattening oils and milk, and consists of fried foods.

So, if you are home then you, um, you will eat the food which has been coming on, like a lot of the choices of oils. Like everything will be prepared in all that pure milk oil, like that ghee thing...and you will always make like fried foods and all that...you cannot say 'no' to all that otherwise people will just say you are just getting too conscious...eat what everyone is eating.

Given the calorie-rich nature of South Asian meals and the traditional methods of preparing South Asian foods, Lola points out how making healthier choices is difficult, particularly because food is traditionally prepared in large quantities for the whole family, so the ability to customize foods to one's taste or preference is limited:

I feel in [Western] culture, everyone gets the choice to make their own food...So you can just choose your way, like a little bit of oil or no oil for your food. But in India or in the [South Asian] way, all of the food is made for everyone, so you don't really get the option to customize it for yourself, and I feel that sometimes your just adding on some unwanted calories just because you cannot have the choice to...because you cannot make, you know, the dishes separately, because it's all time-consuming.

The "family-style" way in which food is prepared in South Asian households means there is little control over how meals are prepared. An expectation in South Asian culture is that

everyone will eat the same foods that are served. It is uncommon for dishes to be customized to an individual's dietary preference or to accommodate specific dietary needs. In order to limit the amount excess calories from foods that are prepared with high amounts of fats and oils Padma explained the only way to avoid excess caloric intake was to reduce portions sizes. She felt that the South Asian way of eating was a barrier to eating healthy and limited her options because meals were cooked in one pot for the whole family. She significantly limited her portions sizes from what she would normally eat, avoided foods high in carbohydrates, like rice and roti, to avoid gaining weight:

It does restrict my options when I'm trying to eat so healthy...when I go over to my mom's I would have like 3 or 4 rotis or something, now I'll have like one and I'll try to eat more protein and veggies. I do feel more restricted, or like on my cheat days I'll have rice.

Not having full control of portions sizes and decisions about what foods to eat, or not eat, at an early age seem to have an impact on eating behaviours as an adult. When reflecting on eating behaviours as a child, participants reflected on how these factors impacted their eating behaviours as an adult, often making them more conscious of limiting portion sizes and the types of foods they ate:

the culture of food and the way food is prepared sometimes can be higher in sugars and fats...I definitely think the way that I ate when I was younger made me a little more heavier than I would have been otherwise... (Lakshmi).

The timing of meals was also a factor that shaped participants' eating patterns. They talked about the fact that in South Asian cultures, meals are often associated with social events or spending time with family and/or friends and they were coordinated with large numbers of people. For instance, families typically eat dinner, which is regarded as the most important meal

in the day, together; while breakfast and lunch are much less of a focus since family members have varying schedules that make it difficult to congregate for these meals. Dinner time is when most of the traditional South Asian meals are served, and it is when families are together. An important finding was that dinner meals are also served later in the evening in traditional South Asian families, ranging anytime between 7pm to 10pm. The reason stated for late meals is that South Asian cooking requires is time consuming and can take a few hours to prepare, so by the time the meals are ready it is later than the typical North American dinner time of between 5 and 7 pm. Maya describes her typical timing of meals:

Because my days end around 3pm to 4pm, that's what I consider lunchtime. So I don't have lunch at noon to 1pm...and I think that's just reflective of me being in elementary school and high school, but that just the time I got home [and] my mom had meals prepared, and that's when I'd actually eat, so it was like that was lunch in my head, and then we'd eat dinner later on. I know people that eat dinner at 5. I'm like that's so weird.

She explains that late afternoon and late evenings are mealtime in her household, which is typical of many South Asian families. Dinner is the main meal that is shared as a family late in the evening. For Maya, she would eat her first meal of the day at 3 to 4pm, skipping breakfast, and snacking throughout the day. Radha describes a similar pattern:

I wouldn't eat breakfast and sometimes I wouldn't eat lunch. So I would come home around 3:30pm and that's when I would have the first meal of my day...we always eat later than Western [culture]...they eat at like 5:30 to 6pm, and [South Asians] eat at like 9pm...when I lived in residence they closed the cafeteria so early. I'm like when am I going to eat dinner...I'm like why would you eat so early, like we're going to get hungry in the middle of the night.

The traditional communal way of preparing meals illustrates the interconnectedness to the social aspect of food and eating in South Asians culture. The participants discussed food and eating when at social gatherings, such as family dinners or weddings, where it is customary to indulge in the abundance of food that is served during the occasion as a compliment to those that are hosting you as a guest. It was mentioned how food is a way of showing appreciation and gratitude, therefore rejecting food that someone has offered would be considered impolite. Even if one is not hungry they mentioned that they felt obligated to eat as to not risk offending anyone. Sundari statement provides insight into why there is such great importance on food, suggesting that accepting food that is offered is a compliment to those that are hosting you as a guest: "...the more you ate the bigger compliment it was to whoever cooked it...so I was brought up, like don't ever complain and don't ever be picky, like because that's an insult..." Maya described experiences of having dinner at a family friend's home. She explains that as a child, because she would eat very quickly, adults would not notice that she finished her meal; therefore they would offer her more food. Regardless of whether she told others she had already eaten, they would encourage her to have more food to ensure she was well fed, and she felt obligated to accept as a courtesy:

If you'd go over to someone's house and they gave me food, often times I'd be really hungry...I'd eat really really quickly...because adults were talking and they didn't realize I ate already and they'd put more...they viewed it as you weren't eating...because in our culture there's an emphasis on being generous with the amount of food...it's like okay, do they have enough.

Although she was full, she had a sense of guilt throwing food away knowing that some of her relatives were less fortunate and do not have the luxury of food abundance. Lakshmi echoed the same sentiments about the complexities surrounding the rejection of a food offering:

You're sort of expected...to have their food or it's like seen as bad. And I have experienced this so many times, because I have refused all the time...they have this sort of culture around eating, and like food is like an important thing.

It is apparent that the preparation of food, as well as the acceptance of food offerings, has great significance in South Asian culture, as it represents a symbol of gratitude to those that prepare it as well as those who consume it. Therefore, rejecting food that someone has prepared for you is viewed as an insult to the person who prepared it or is offering it. Radha demonstrates the impact that refusing food played in her relationship with her father. She described using food as a way to demonstrate her anger towards her father, who was her primary guardian and was responsible for meal preparation for her and her sibling. She described her refusal to eat when she was upset with her father because he had cooked the food, therefore, to show him how upset she was she would not eat:

I know like sometimes if I fight with my dad I would be like 'I'm not eating dinner'... it'd make my dad angry...I felt like not eating would just give me more control...I think I more so did that because my dad made the food, so now I'm not going to eat because you made it...so it's like I'm gonna starve myself so you feel bad. I think it was rational. Like you made it so I'm not going to eat it.

4.5 CONCLUSION

This chapter highlighted the most prominent themes that arose from the data in my discussions with the participants. The social and cultural influences that impacted the women's views on what constitutes beauty, and its cultural significance in South Asian culture were unpacked to reveal that the deeply rooted cultural practice of arranged marriage played a significant role in terms of placing a great deal of importance on beauty. The women also discussed how beauty impacted their body image and self-perceptions by discussing the role that people within their

South Asian communities played on influencing the way they perceived their bodies. They discussed issues surrounding the way others openly comment or critique women on their appearances and attribute these types of encounters as an apparent cultural norm. Consequently, the women felt a heightened sense of self-awareness about their bodies and engaged in abnormal and unhealthy eating behaviours which led some women to suffer serious health ailments. The next chapter discusses the implications of these findings in relation to how they contribute to the research literature and knowledge about beauty, body image, and health among youth South Asian women, particularly those living in multi-cultural or bi-cultural settings.

Chapter 5 - Findings

5 BEAUTY, BODY IMAGE AND HEALTH

5.1 INTRODUCTION

The issues of beauty and body image have a powerful impact on the lives and health of young women. However, for traditional South Asian women raised in environments where values and hegemonic Western influences coexist the impact is more pronounced. This study was designed to understand how the complex cultural context in which South Asian women live shape their experiences with disordered eating behaviours. This research revealed several key insights through which their lives and ideas about their bodies are powerfully governed and constrained, most notably gendered norms regarding physical appearance. Gender norms have long been central to how young South Asian women are raised and they tie very deeply into traditional ideas about the links between physical appearance and marital suitability. Although young South Asian women today exercise greater autonomy in the decisions they make about marriage than was the case in the past, the extensive criteria against which their physical appearances are measured continue to circulate in their socio-cultural and familial lives and have significant impact. Many participants experienced these judgements of their bodies and themselves as oppressive, often turning this litany of evaluation onto themselves through extreme forms of bodily surveillance. This examination of how they navigate and evaluate their appearances as well as their ideas about themselves within the context of their daily lives and the complex cultural in which they live is unique contribution to the literature. My study also highlights how the competing South Asian ideas of beauty and body image and those extolled within mainstream Western society affect their body surveillance, eating behaviours, and physical and mental health.

In this chapter, I demonstrate how my research contributes to existing studies on the issues of gender roles, beauty, body image, and health among young South Asian women, particularly those living in familial setting defined by traditional cultural values as well as those relating to dominant Western society. I will examine the socio-cultural significance of body and gender for my participants, then discuss how social commentary, particularly shaming women for lacking ideal characteristics of beauty affected the women, followed by a discussion of how food and eating was used as a way of regulating the complex notions of gender and body that influenced their self-perceptions. I then shift to a discussion of the practical relevance of my findings for health-related interventions for this important but often over-looked population.

5.2 Socio-Cultural Significance of Body and Gender

As a predominantly patriarchal culture, South Asian traditions have a long history of placing a great deal of importance on social status and power ideologies that are disproportionately androcentric. A man's value is measured on material criteria and having an advanced education, career and income status are valued above physical attractiveness (Chantler, 2014; Samuel, 2010; Talbani & Hasanali, 2000). It is very different for women, and as my participants discussed there is a great deal of importance placed on women's physical appearances more so than their vocational accomplishments or other personal attributes, especially under circumstances when arranged marriages are considered. In these circumstances the primary focus is on beauty because a man's family wants to ensure that future grandchildren will inherit good genetic qualities, which are thought to be significantly impacted by the physical attributes of the woman (Talbani & Hasanali, 2000). Advanced education and career play a decidedly secondary role for women when they are considered for marriage, although this is changing among the middle and upper classes and education is becoming more valued as advanced education viewed as an indication of higher social status.

The long-standing practice of arranged marriages retains a significant place in South Asian culture, and for women getting married and raising a family are part of their preordained role in life. The pre-eminent socio-cultural roles for women remain being the family caregiver and taking care of household chores, whereas men are expected to take on roles outside of the home such as working to earn the income needed to provide for the family. Traditionally a woman's parents, or elders in the community, take the lead on finding a suitable male partner for her (Talbani & Hasanali, 2000; Samuel, 2010). This often means that women and their families may not have the opportunity to spend much time with or get to know the prospective marriage partners, because the activities regarding the marital arrangements are in the hands of others. Given the formulaic or business-like approach to marriage in this setting, men and women are assessed not on their personalities but on gender-specific qualities, which are then used to determine their value and suitability as a marriage partner.

Throughout conversations with my participants, being beautiful to enhance their prospects for marriage was a recurrent theme. It is apparent that historical notions of attractiveness have maintained their relevance and continue to influence young women today. The women in my study discussed feeling that if they were more beautiful they would be more likely to find men that were attractive and had good jobs. Beauty, for South Asians, represents higher ranks in social class and economic hierarchies and is especially meaningful among South Asians where social status is based on a caste system (Samuel, 2010). The specific physical traits that define beauty are rooted in beliefs and power systems inherited during the colonial era, where certain physical characteristics that are typical of white Western women, such as light skin, were associated with power, wealth and prestige; therefore women were more highly valued for being beautiful (Hunter 2011; Sahay & Piran, 1997).

As the literature highlights, and my participants confirmed, beauty is a fundamental attribute to ensure high-quality marriage prospects for women and their families to maintain a

respectable level of financial and social status. As a consequence of the substantial importance of marriage as one of the main cultural roles that women are expected to fulfill, there is a great deal of pressure placed on them to alter their appearances to reflect certain physical characteristics that align with the ideals of beauty in South Asian culture.

All of my participants stated two key attributes that were important qualities associated with being beautiful that align with findings in the literature on body image among South Asian women: fair skin and thin physique. Certain characteristics that define attractiveness among South Asians have remained consistent over time, for instance notions that fair skin is associated with being more attractive. However, there has been a shift in ideals associated with body weight/shape and attractiveness, which occurred post-industrial revolution. There was a shift from admiring fuller-bodied women to favouring thinner bodies (Bush et al., 2001). But as this shift in ideals of body shape occurred the cultural importance of food and eating in South Asian culture has remained consistent over time, which can conflict with a women's efforts to maintain a thin body through healthy eating (Chapman et al., 2011; Choudhry, 1998; Chowbey, 2017). The cultural significance of food and eating in South Asian culture will be discussed later as it pertains to the women's discussions of body image and their health.

5.3 Social Commentary and Body Shaming

Body weight and shape were characteristics of beauty that were significant issues for my participants that they felt others used to judge or socially control them. The pressure women feel from family, friends and others in the South Asian community, combined with the influence of Western culture's emphasis on thinness, reinforce the message that women should maintain thin body figures. Messages targeting women that prominently focus on losing weight and being thin can be damaging to self-esteem and make women feel inadequate about their bodies, influencing

them to resort to drastic methods to change their bodies until they feel they meet societal expectations. For my participants this functioned as a form of social control that dictated how they perceived themselves and monitored their body.

The literature on body image and eating disorders among South Asian women has examined the struggles women endure when it comes to gaining a sense of autonomy and independence, which causes them to internalize the stress and conflict they experience. The internalization of their body-related struggles is hypothesized to increase women's risk of developing an eating disorder (Chowbey, 2017; Valliantose & Raine, 2008; McCourt & Waller, 1996; Mujtaba & Furnham, 2001; Mumford et al., 1991; Reddy & Crowther, 2007). The literature has examined how women's struggles with forms of control, particularly parental control, impact their health and eating behaviours.

My research uniquely highlights the powerful role that 'informal' or normalized social commentaries about women's appearance plays in women's lives, as a form of social control that governs their behaviours in public events and internally, often driving them to exact severe forms of surveillance and self-harm on their bodies. The women interviewed explained that in South Asian culture it was quite normal for people to openly comment on someone's appearance, particularly their weight, and overtly remark if they thought a woman had gained or lost weight. Comments like these often came from family or friends at social gatherings and imply a degree of normalcy with making candid remarks about someone's weight. They discussed how they felt pressure from other South Asians in their families and in the community to look a certain way, specifically to attain appearances that aligned with socio-cultural expectations of beauty, for example having long hair, light skin, being tall, and being thin, which are all physical traits that the women identified as characteristics that would make them more beautiful. Given the inherent limitations to be able to change physical appearances, the stress the women felt to look a certain way had a damaging effect on their self-perceptions of their bodies and their self-esteem when

were unable to achieve people's expectations and continued to receive negative comments from others about their appearances.

The impact that commentary has on women is strongly associated to the degree of body dissatisfaction that women experience and to the increased risk of developing an eating disorder. The literature on eating disorders describe this kind of negative commentary as 'teasing', and examines the effect it has on women's body dissatisfaction (Menzel et al., 2010; Keery et al., 2005). The term 'teasing' is a "...form of negative verbal commentary..." about one's physical appearance (Reddy & Crowther, 2007, pp.46). The women interviewed did not describe these experiences as 'teasing' or frame them as a malicious attempt by others to make fun of their appearances, rather they spoke about it in more general terms as observations others made to them about their bodies. This is most likely due to the deeply entrenched nature of these 'commentaries' and how normalized they are within the young women's socialization processes. That said, these assessments by others certainly fit within most definitions of teasing or, more accurately, body shaming because these remarks are part of larger systems of power and gendered governance and they are not only perceived negatively by the women, they have very negative impacts on how they viewed their bodies. The literature on eating disorders in South Asian women has explored the impact of teasing on women and demonstrated a strong relationship between teasing and disordered eating behaviours, and my research confirms this linkage.

When criticisms are conveyed to women about their bodies it can trigger an array of negative emotions and body perceptions that prompt women to develop a skewed body image (Iyer & Haslam, 2003). For the women in my study, comments made by their friends and family members had a strong influence on shaping the way they perceived their bodies and influenced their eating and dieting habits, which negatively impacted their health. In terms of body shape the opinion of others tended to focus on being "too fat" or even in some cases "too skinny",

which are highly subjective measures that left much to interpretation regarding what “too fat/skinny” meant for them. Some said they took comments about being too skinny as a compliment and used it as a motivator to continue their weight loss strategies, and could possibly contribute to the development of eating disorders among young South Asian women. Others who received comments about looking like they had gained weight were triggered to begin altering their eating habits and exercise excessively to lose weight. Regardless of whether comments were directed at weight gain or weight loss, all participants described this aspect of their life as an ongoing struggle to maintain an ideal weight/shape based on how others judged them, and consequently had a negative impact on their physical and mental health.

5.4 FOOD, EATING AND HEALTH

Several factors influence women’s eating behaviour, some of which have been discussed in the previous sections, including socio-cultural expectations for South Asian women and body shaming, which amplify their risk of engaging in unhealthy ways of altering their bodies through dieting and changing their eating behaviours (Daye et al., 2014). The entrenched forms of surveillance regarding body image and size also dictate how these women approach food and eating. To that end, participants discussed various factors, many of which involve weight management and a desire to remain within an “acceptable” range that is dictated by the combined influences of South Asian and Western cultural forces.

It is a common perception among South Asian women living in Western societies that the food of their heritage is less healthy in comparison to diets from Western or European cultures because South Asian foods are typically made with high-calorie ingredients such as fatty oils, butter and starches, and few raw vegetables (Chapman et al., 2011). The nutritional content of traditional South Asian foods were described by my participants as a barrier to achieving their weight-loss goals, and it was a struggle for them because many of them lived with their parents who prepared South Asian dishes for the family regularly. To add to their struggle with South

Asian food, the significance that food has in a social context for South Asians is profound, as it symbolizes love and gratitude (Chapman et al., 2011; Chowbey, 2017; Valliantose & Raine, 2008). If they turned down food offerings, especially food that was prepared by loved ones, it would be considered rude or insulting to those who prepared the meal. My participants described alternative ways they would limit their caloric intake by manipulating portions sizes and restricting the amount of food they consumed in a day, which led to some of the women to experience serious health consequences, such as diabetes and anorexia. A fascinating finding from some of my participants was the influence of their fathers' eating habits on their own dieting and eating behaviours. The women talked about hiding their unusual behaviours from others so they would not be ridiculed for dieting, but when their fathers adopted a lifestyle of healthy eating to better manage their health, the women adopted similar eating habits as a way to manage their weight and not be criticized by their family for dieting for the purposes of weight-loss. The women's intentions of adopting similar eating habits was driven by a desire to lose weight rather than improve their health, especially since some of the women developed serious health issues.

The women rarely considered the negative impact that their eating behaviours could have on their health in the short- or long-term, as their immediate motivation to lose weight exceeded their desire to maintain their health. Health issues such as type-2 diabetes and anorexia nervosa were conditions that beset the women, often the product of their excessive restrictive eating patterns. Other participants also experienced mental health conditions, such as body dysmorphia, that may be linked with their severe eating behaviours, which could also put them at higher risk for developing an eating disorder or other health complications.

The data gathered from my participants inform the broader literature on eating disorders from the socio-cultural perspective of South Asian women which challenges the more commonly held notions that eating disorders are dominantly characterized by 'fear of fatness' and weight

gain. Beyond these dominant discourses about eating disorders, the experiences of my participants challenge ideas that eating disorders are primarily related to concerns about their weight which impacts their body image, but rather, for some women a series of complex social interactions and cultural factors impact their self-perceptions, self-esteem and self-worth to a greater extent than simply being dissatisfied with their weight.

The methods that South Asian women I interviewed described using to manage their weight could be classified as a feeding and eating disorder according to the *DSM-V* diagnostic criteria. Because the criteria for diagnosing an eating disorder was vague in previous editions, it was difficult for health practitioners to discern if certain eating behaviours were in fact an indicator of a developing a more dangerous type of eating disorder. With the updated criteria, South Asian women's abnormal eating habits, including the behaviours described by my participants, could be classified as a problematic behaviour that could be treated in a timely manner and prevent a woman's health from deteriorating.

Chapter 6 – Conclusion

This study explored socio-cultural influences that impacted South Asian women's self-perceptions and eating behaviours. The findings revealed that cultural gender ideologies played a substantial role in shaping the way women viewed themselves and their bodies. Notions of beauty and body, the cultural importance of marriage, and social commentary were found to amplify the degree to which women were dissatisfied with their bodies and influenced them to strictly monitor their bodies and modify their eating behaviours to meet cultural expectations associated with beauty in South Asian culture. The women's perceptions of their own physical appearance are framed within the context of their South Asian cultural identity and cultural norms of beauty.

It is evident from the findings presented that culture has a significant influence on women's body image and consequently their health. Beauty and gender cultural ideologies were complex aspects of life that South Asian women struggled with balancing. Characteristics that defined beauty, most notably skin tone and body shape/weight, were highlighted as traits that my participants described as attributes of their physical appearance that other South Asians judged them on most often. They struggled to attain an ideal body image based on comments that they received from others about their weight, and perceived the commentary as pressure to uphold cultural expectations of their appearances.

Beauty was associated with the ability to find a husband by the women I interviewed. A concern for them and their families was that if they were not beautiful, meaning they were not thin or did not have fair skin, they would not find a husband that they were attracted to. Their families expressed discontent with their appearances in reference to their ability to find a husband if they put on weight or were tanned from being in the sun. The women would regulate

their bodies as much as possible to stave off criticism about their bodies. To add to the criticisms they heard from family regarding their appearances, people outside of their families, such as friends, family friends, or extended relatives would openly pass judgements to women about their body, particular when they had gained weight. This commentary from people outside of their family magnified their body dissatisfaction and provoked them to engage in body surveillance measures to maintain stay thin. The women mostly modified their eating behaviours by restricting the types and quantities of food to limit calories they consumed in each day. Social commentary about their bodies along with their unhealthy eating behaviours contributed the physical and mental health issues they experienced.

The disordered eating behaviours my participants adopted were a consequence of their insecurities which stemmed from harsh criticisms of their bodies. They manipulated their food and eating habits to lose weight or maintain their thin physiques, and for some the perpetual struggle to stay thin or achieve a body they felt was ideal led them to suffer serious health issues such anorexia nervosa, diabetes, and malnutrition. Their weight-loss efforts were complicated by the cultural significance of food in South Asian culture. Because food is symbol of love and gratitude refusing food is culturally inappropriate. The symbolic implication of food made it difficult for the women to restrict their intake when food was offered in social settings. They would use alternative ways to restrict their intake by modifying portion sizes or going through periods of starvation in anticipation of having food offered to them at a social event. In everyday settings, meals were cooked in large quantities for families, and even in the home setting it was challenging to restrict food as the expectation is that the family will eat the food that is prepared. In these cases, women would try to avoid eating altogether, or eat minimally to uphold cultural values but still fulfill their weight loss goals.

As the result of culturally rooted norms and traditions related to food, eating, and physical appearances, South Asian women are faced with compounding pressures to achieve the

ideals of South Asian beauty. Struggles with body weight and shape, in particular, are complicated by the normalization of body shaming among South Asians, potentially conflicting Western-South Asian cultural understandings of body ideals, the pressure for women to meet beauty ideals, and the importance that food has in social contexts in South Asian culture. When dichotomies exist between two cultures that are closely intertwined, as they are for the women in this study, socio-cultural conflicts can be the source internalized struggles with body surveillance and self-esteem that may influence women to engage in behaviours that negative health consequences.

5.5 Limitations/Future Directions

A limitation of this study is that it does not explore the impact that the findings on beauty, body image and health had on the women's perceived lack of autonomy and control over their lives. The literature cites cultural conflict and issues with parental control as a key contributor to South Asian women's increased risk of eating disorders as it is attributed to the internalization of the stresses and tensions that such conflicts impose on them, thus manifesting into disordered eating. Although the mechanisms that associate internalization of conflict with the development of eating disorders is not well-understood, several studies have related the cultural and parental conflict as phenomena that increase South Asian women's risk of engaging in disordered eating. It is worth further investigating the complex psychological and sociological mechanisms that cause women in a state of cultural conflict to manifest their tensions into the form of eating disorders.

Another limitation of this study is the same sample size used to examine these complex issues. While the sample sized used in this study was able to shed light on various impacts that influence disordered eating, it is difficult to draw conclusions about how complex social and cultural experiences influence South Asian women's increased risk of developing eating disorders. Future studies could explore the main findings of beauty, body image and health

among a larger study population of Canadian-South Asian women to allow for more robust findings.

5.6 Recommendations

This study sheds lights on the complex mechanisms that contribute to South Asian women's increased risk of developing eating disorders, particularly the impact that negative commentary about women's bodies has on their self-perceptions and eating disorder risk. As I studied the lived experiences of South Asian women that engaged disordered eating behaviours, the findings uncovered a greater understanding of cultural norms that might be contributing to their heightened sense of dissatisfaction with their bodies. I have examined the cultural and gender ideologies related to notions of beauty, body image, and health in this study, which illuminates the lived experiences of young South Asian women and contributes new ideas to the empirical literature that may also be of practical value in developing programs and services that target the unique needs of this specific population of women.

The findings from this study, as well as from the broader literature on eating disorders in South Asian women, can inform primary care practitioners and mental health workers to identify problematic eating behaviours and the circumstances that put South Asian women at risk of developing eating disorders and implement more culturally relevant approaches to managing women's health in terms of making accurate diagnoses of eating disorders and prescribing appropriate treatments, such as culturally sensitive mental health counselling, to prevent their health from declining. With a greater understanding of South Asian women's experiences, health professionals can provide opportunities to educate women who might not be aware that their eating habits are putting them at risk for health consequences, and empower them to understand more about why they might be engaging in such behaviours by considering culturally specific factors that impacting their self-esteem and body image.

South Asian communities could also benefit from educational opportunities that bring awareness to the South Asian women's heightened risk for eating disorder development. Greater awareness of the issues that South Asian women are faced with in relation to body image and body surveillance can make people more conscious about discuss women's bodies openly and avoid commentary that might negatively effect women's health.

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Appendix A

Informed Consent Agreement & Letter of Information

Research Subject Informed Consent and Letter of Information

A Narrative Study of Culture, Gender, and Health Discourses of Young South Asian-Canadian Women with Eating Disorders

Principal Investigator

Dr. Treena Orchard, PhD, Assistant Professor

Western University

Co-Investigators

Ms. Nazia Bhatti, MSc. Candidate

Introduction

You are being invited to participate in this research study designed to gather information about your views, opinions, and experiences on the topics of gender, body, health and eating behaviours to understand how these topics impact the lives of young South Asian women living in Canada. You have been invited to be a study participant as you are a suitable candidate for participation. The information will be used for a Master's thesis project, and the study results may be used to inform further research in this area of study and/or be presented in peer-reviewed journals and/or at conferences.

Background/Purpose

Background

Research on eating disorders shows a rising trend among females between the ages of 15 to 24 (Keel, 2010). Eating disorders are a group of serious conditions that involve a preoccupation with food and weight, leading to serious physical and mental health problems (Gordon et al., 2010). In response to an increasing number of cases of eating disorders amongst children and adolescents, the World Health Organization (WHO) made eating disorders a primary area of focus beginning in 2003.

Eating disorders have several physical and mental health implications for young South Asian women, including short-term and long-term problems, including hypertension, hypothermia, electrolyte imbalances, endocrine disorders, anemia, dehydration, infertility, and kidney failure to name a few. These issues can often be resolved by reverting eating behaviours back to normal (Gucciardi et al., 2004). As well, psychological and sociocultural issues can cause related mental health problems, such as depression, anxiety, substance abuse, and suicide (Gucciardi et al., 2004).

It is apparent from a review of the sociological, psychological, and health sciences literature on eating disorders and body image that most of the studies that have been published discuss the prevalence, risk and protective factors for disordered eating and body image among females, and examine it from the perspective of Caucasian populations of North American or European decent.

Some studies suggest that the prevalence and risk of disordered eating behaviours is greater among South Asians women than white women, and is reportedly due to acculturation to Western ideals of body appearance. Acculturation is the process of adopting the ideas and patterns of behaviour of the culture within which you are living. Acculturation theories of body image suggest that eating disorders can develop when people of non-Western cultures adopt Western norms of body weight and shape, particularly favouring thinner physiques, and a strive to attain the “ideal” body image that is often reflected in the media in order to fit in with the dominant Western culture (Reddy & Crowther, 2007). This strive to fit in is believed to have a significant impact on increasing the risk for eating disorders among ethnic females (Reddy & Crowther, 2007). However, as more research emerges, psychological and sociocultural mechanisms, aside from acculturation to Western culture, have been shown to also influence eating disorder risk (Anand & Cochrane, 2005; Mumford et al., 1991; McCourt & Waller 1996; Kennedy et al., 2004). Some research has shown that for young South Asian women, relationships with family and peers, and struggling to balance traditional gender and cultural values while living in Western societies may have a stronger influence on eating disorder risk, as eating disorders are often present in this population without reports of body dissatisfaction or an aversion to gaining weight (Anand & Cochrane, 2005; Kennedy et al., 2004; McCourt & Waller 1996; Mumford et al., 1991; Reddy & Crowther, 2007).

In spite of the expanding knowledge on eating disorders in South Asian women, there still remain gaps in understanding the socio-cultural and psychological mechanisms that are involved. Currently there is lack of research examining the lived experiences of South Asian women with eating disorders, which can unpack some of the underlying socio-cultural factors that are thought to impact eating behaviours in young South Asian women. This study aims to examine the lived experiences of young South Asian women to gain an understanding of how culture and gender is experienced from the perspective of South Asian women living in Western society using narrative inquiry (described below). Also of interest is how their experiences have influenced the way they perceive their bodies and interact with their environment, including their eating behaviours and social interactions, and what impact this has on their physical and mental health. A study of this nature is an important contribution to the literature on disordered eating in South Asians, as there is a need for further exploration into these areas from the perspective of those who experience it firsthand, especially considering these issues have shown to have a significant effect on this population (Anand & Cochrane, 2005; Hill & Bhatti, 1993; Kennedy et al., 2004, Khandewal et al., 1995; McCourt & Waller 1996; Mumford et al., 1991; Reddy & Crowther, 2007).

Purpose

This study has the potential to contribute to the currently limited body of literature on this subject and begin to provide an understanding of how young South Asian women locate their experiences with eating disorders and body image perceptions in relation to current assumptions about eating behaviours and mental health. A narrative study, which will examine the experiences of eating disorders and the daily struggles of South Asian-Canadian women, can inform new directions for health services and preventative programs tailored to meet the specific needs of this population that may not be attended to with existing programs that currently do not take into consideration ethnic differences. In addition, there is the potential to explore areas of further education for women on eating disorder risks and prevention, and empower women to effectively manage their health in the face of cultural or gender struggles.

Reason for participation

You are being asked to participate because you are a South Asian-Canadian female between the ages of 18-30 that has experienced abnormal eating patterns at some point in your lifetime.

Up to 6 women will participate in this Western University study and it will take approximately 6-8 months to complete. It is expected that your involvement in the study will be for the duration of 1-2 hours on a maximum of 2 occasions.

Study Design

This study will employ narrative methodology. Narratives are a type of qualitative research that involves hearing stories from the study participants about a particular event in their life, an extended story about a particular aspect of one's life, or a story about one's life as a whole (Chase, 2005). The data collected from narratives are audio recorded, transcribed and thematically organized to order to understand the meanings that people give to certain experiences or events, and to understand the context from which people experience life/events and what those experiences are like for someone of a particular social group, gender, or culture (Fraser, 2004).

Much can be learned from narratives, as the stories unfold in a natural sequence as told by the narrator/study participant. Narratives have the ability to gain an understanding of how subjects construct their lived experiences (Chase, 2005). The sequence of events and the manner in which a research participant chooses to tell their story can provide great depth to the information collected (Chase, 2005).

This study will use interviews to collect information about young South Asian women's experiences with eating disorders. The interview format allows the researcher and the study participant to engage in meaningful dialogue in which significant aspects of the narrator's life and particular events will be discussed (Lieblich et al., 1998).

The researcher will guide the interview subjects to discuss specific aspects of their lives; specifically those aspects that have influenced abnormal eating behaviours. General, semi-structured questions will be used to prompt subjects to discuss the topic of interest. To begin, vignettes will be used as an icebreaker at the beginning of the interview and initiate discussions on topics of interest. A vignette is a brief anecdote, story, or image that is used to initiate discussion on a particular subject. Subjects will then begin to tell their stories, including, but not limited to: what topics to discuss; the sequence of events; and the meanings they attribute to their experiences, culture, gender and health (Chase, 2005). The interviews will be audio recorded during the interview process and the researcher will also take notes on a laptop.

To participate in the study you must meet all of the following criteria:

- Canadian-South Asian women (Indian, Pakistani, Bangladeshi, Sri Lankan)
- First generation, either born in Canada or living in Canada for the majority of your life
- Between the ages of 18-30 years old
- Have experienced abnormal patterns of eating at some point in your life

If you do not meet all four criteria mentioned above, you are not eligible to participate in this study.

Procedures

- You will be asked to participate in one-on-one interviews with the researcher on a maximum of two occasions.
- Each interview will be approximately 1-2 hours long.
- Each interview will take place in a mutually agreed upon location.
- All interviews will be completed before August 2014.
- During the interviews the researcher will ask you some general questions about your opinions and views on current events in mainstream media (a vignette) and about your personal experiences on topics related to eating patterns, family, culture, and social experiences. You and the researcher will talk about these topics with you and anything related to these topics that you would like to discuss.
- With your permission, the interview will be audio recorded to facilitate collection of information, and later transcribed for analysis.
- All information you provide is considered completely confidential. Your name will not appear in any thesis or report resulting from this study, however, with your permission anonymous quotations may be used.
- Data collected during this study will be retained for 5 years in a locked filing cabinet in my supervisor's office on Western University's campus. Only researchers associated with this project will have access to the information.

Voluntary Participation

- Your participation in this study is voluntary. You may decide not to be in this study, or to be in the study now and then change your mind later. You may leave the study at any time without any negative consequences.
- We will give you new information that is learned during the study that might affect your decision to stay in the study.
- You may refuse to answer any question you do not want to answer, or not answer an interview question by saying “pass”.

Withdrawal from Study

If you request to be withdrawn from the study, advise the researcher of your intention to do so. If you decide to withdraw from the study, you have the right to request withdrawal of information collected about you.

Risks

There are no known risks to you as a participant in this study. Potential risks may include elicitation of negative emotional responses to some of the topics being discussed. In the event that you experience any discomfort, negative emotions, or distress, notify the researcher right away and the interview will be paused. If/when you feel comfortable to continue you may let the researcher know and the interview will continue or you can reschedule to continue at another time. If you experience discomfort or distress the researcher will provide you with resources for services that you can access for further assistance.

Benefits

A potential benefit of participating in this study is that the information you provide will contribute to the body of research examining issues surrounding gender, body, health and eating behaviours. The information can be used to help improve health services and programs that are provided to South Asian-Canadian women.

A potential benefit to you personally by participating in this study may include providing you a safe and confidential space for you to speak to someone about topics or issues that are important to you but that you may not otherwise discuss with peers or family members.

Confidentiality

Your identity in this study will be treated as confidential. The results of the study, including transcribed data, may be published for the purposes of a Master’s thesis project, publication in peer-reviewed journals, and/or presentation at conferences. Your name or any identifiable references to you, such as family members names, birth dates, addresses etc. will not be published or presented. Names and identifiers will be removed and replaced or modified with alternate identifiers. For example, your name will be replaced with the label “Subject A”.

The persons conducting this study may inspect any records or data obtained as a result of your participation in this study. These records will be kept private and confidential. Any data that is transcribed or recorded will be stored on a password-protected computer, on a data stick, and on DropBox.com. The files stored on these devices will also be password protected.

Compensation

You will not have to pay for any of the interviews you are involved with this study. You will be compensated \$20.00 for each interview that you complete, for a maximum total of \$40.00 for participating in this study.

If unforeseen circumstances arise that require withdrawing from the study early, you will be compensated for participating in interviews that you completed. For example, if you have to withdraw from the study during or after the first interview, hence not completing the second interview, you will be provided \$20.00 compensation for the first interview but will not receive compensation for the second interview.

Additional costs to you for participating in the study are minimal. Potential additional costs to you might include the cost for transportation to the mutually agreed upon location for the interviews (eg. bus fare, taxi fare, mileage/gas), meals/food, your time, cell phone/data usage etc. You will not be compensated by the study for these or any other additional costs.

Rights as a Participant

- In the event that you experience any discomfort, negative emotions, or distress, notify the researcher right away and the interview will be paused.
- If you experience discomfort or distress the researcher will provide you with resources for services that you can access for further assistance.
- You do not waive any legal rights by signing the consent form.

Questions About the Study

If you have any questions about your rights as a research participant or the conduct of this study, you may contact Scientific Director, Lawson Health Research Institute.

Consent

I have read and understand this consent form, and I volunteer to participate in this research study. I understand that I will receive a copy of this form. I voluntarily choose to participate, but I understand that my consent does not take away any legal rights in the case of negligence or other legal fault of anyone who is involved in this study.

Print Name

Signature

Date (DD-MMM-YYYY)

Appendix B

Version Date: April 22, 2014

FileNo: 104767

Title: A Narrative Study of Culture, Gender, and Health Discourses of Young South Asian-Canadian Women with Eating Disorders

Start Date: 01/11/2013

End Date: 31/10/2014

Keywords: eating disorders, Body Image, South Asian, Women, gender, health

Project Members

Principal Investigator

Prefix: Dr.

Last Name: Orchard

First Name: Treena

Affiliation: Health Sciences\Nursing

Rank: Assistant Professor

Gender: Female

Email:

Phone1:

Phone2:

Fax:

Mailing Address:

Institution: Western University

Country: Canada

Comments:

Others

Rank	Last Name	First Name	Affiliation	Role In Project
Masters Student	Bhatti	Nazia	Health Sciences	Co-Investigator

Common Questions

1. Registration Information

#	Question	Answer
1.1	Do you confirm that you have read the above information and that based on that information you are completing the correct form?	Yes
1.2	Has this study been submitted to any other REB? If yes, please include the approval letter (or relevant correspondence).	No
1.3	If YES is selected in question 1.2 above, please indicate where this project has been submitted and when.	
1.4	Indicate the funding source for this study or if there is no funding simply indicate "None".	None
1.5	If you have indicated a funding source in question 1.4 above, please specify the name of the funding source selected as well as the title of the grant and if applicable the ROLA number.	
1.6	Is this a sequel to previously approved research?	No
1.7	If YES is selected in question 1.6 above, what is the REB number and what are the differences?	
1.8	Is this a student project?	Yes - Masters
1.9	Is this a multi-site study?	No
1.10	If YES has been selected in question 1.9 above, name the lead site and project leader for the study. If the study is administered by a Coordinating or Contract Research Organization (CRO) provide the name and contact information.	
1.11	Please list the names of ALL Local (Western affiliated) team members who are working on this project. Please ALSO list their ROLE in the project, i.e. what exactly is it that the team member will do in this study? Please see the "i" for this question for instructions on how to	Dr. Treena Orchard - supervising Masters student project Dr. Lilian Magalhaes - advisory committee member Dr. Kristin Lozanski - advisory committee member Nazia Bhatti, MSc. Student - Recruitment, data collection, data analysis

	link their Romeo accounts to this form so they have access to it.	
1.12	Are the investigator(s) based at any of the sites below or will the study utilize any patient data, staff resources or facilities within any of these sites? (Please indicate all applicable sites and read the associated notes found in the blue information icon above)	No
1.13	If this form was started by a team member, has the role of Principal Investigator been changed to the Faculty member who will hold this role for the study? This is required for review of your submission, and any forms submitted without this change being made will be returned without being reviewed. (The blue information “i” has the instructions on how to change the role of PI.)	Yes
1.14	Please provide a lay summary of the study (typically fewer than 5 lines).	Qualitative narrative inquiry data will be collected on the life experiences of South Asian women related to issues surrounding gender, body image, disordered eating, and health (physical and mental health). One-on-one open-ended interviews will be conducted with 5-6 South Asian women residing in London, Ontario, between the ages of 18 to 30 years.

2. Methodology

#	Question	Answer
2.1	Outline the study rationale including relevant background information and justification. Cite references where appropriate.	Research on eating disorders shows a rising trend among females between the ages of 15 to 24 (Keel, 2010). Eating disorders are a group of serious conditions that involve a preoccupation with food and weight, leading to serious physical and mental problems (Gordon et al., 2010). Body image and eating disorders are interconnected issues that often coexist. Those that experience negative attitudes about their body appearance, for example feeling that they are overweight, can manipulate their eating behaviours by portion controlling their food, restricting themselves from eating, or engaging in bingeing and purging patterns, in an attempt to control their weight and attain a desired body image. In response to an increasing number of cases of eating disorders amongst children and

	<p>adolescents, The World Health Organization (WHO) made eating disorders a primary area of focus beginning in 2003. As eating disorders tend to begin in the early stages of life and progress into adulthood (Keel, 2010), the WHO aimed to address the problem from its onset. Eating disorders have several physical and mental health implications for young South Asian women, including short-term and long-term problems, including hypertension, hypothermia, electrolyte imbalances, endocrine disorders, anemia, dehydration, infertility, and kidney failure to name a few. These issues can often be resolved by reverting eating behaviours back to normal (Gucciardi et al., 2004). As well, psychological and sociocultural issues can cause related mental health problems, such as depression, anxiety, substance abuse, and suicide (Gucciardi et al., 2004). As the result of such health problems, one's quality of life is severely affected. Loss of quality of life and productivity in one's personal and professional life can have severe consequences for South Asian women, as eating disorders tend to be a problem that is dealt with privately (Gucciardi et al., 2004; Bradby et al., 2007). As a result, help is often sought only when physical health is severely affected and hospitalization is required (Gucciardi et al., 2004). It is apparent from a review of the sociological, psychological, and health sciences literature on eating disorders and body image that most of the studies that have been published discuss the prevalence, risk and protective factors for disordered eating and body image among females, and examine the phenomena from the perspective of Caucasian populations of North American or European decent. Much of the research on eating disorders emerges from North America and Europe where Caucasians are the majority; therefore research samples are gathered more from this population than others. However, studies that have included women of varying ethnicities usually provide comparisons to Caucasians, and the results have shown that eating disorders are a greater concern for some ethnic groups than they are for Caucasians (Keel, 2010). In response to these findings, eating disorder research among ethnic populations is being acknowledged as a growing area of interest and concern (Keel, 2010). Current research is expanding examination of eating</p>
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	<p>disorders in ethnic populations, with particular focus on South Asian women and adolescent girls (Keel, 2010). Some studies suggest that the prevalence and risk of disordered eating behaviours is greater among South Asians than Caucasians, and is reportedly due to acculturation to Westernized body appearance ideals. Acculturation theories of body image suggest that eating disorders can develop when people of non-Western cultures assimilate to adopt Western norms of body weight and shape, particularly favouring thinner physiques, and a strive to attain the “ideal” body image that is often reflected in the media in order to fit in with the dominant Western culture (Reddy & Crowther, 2007). This strive to fit in is believed to have a significant impact on increasing the risk for eating disorders among ethnic females (Reddy & Crowther, 2007). However, as more research emerges, psychological and sociocultural mechanisms, aside from acculturation to Western culture, have been shown to also influence eating disorder risk (Anand & Cochrane, 2005; Mumford et al., 1991; McCourt & Waller 1996; Kennedy et al., 2004). Some research has shown that for young South Asian women, relationships with family and peers, and struggling to balance traditional gender and cultural values while living in Western societies may have a stronger influence on eating disorder risk, as eating disorders are often present in this population in the absence of reports of body dissatisfaction or an aversion to gaining weight (Anand & Cochrane, 2005; Kennedy et al., 2004; McCourt & Waller 1996; Mumford et al., 1991; Reddy & Crowther, 2007). There remains much work to be done to further explore the extent to which relationships, gender, and culture play a role in the development of eating disorders in South Asian women, since the small body of emergent research has only begun to uncover these links. In addition, to exacerbate any effects of cultural influences, eating disorders have a tendency to become generational acquisitions; where problematic eating behaviours affect psychological eating patterns of children with mothers that battle with disordered eating (Gucciardi et al., 2004). Mothers with eating disorders can create abnormal eating patterns for their children by demonstrating irregular eating patterns, detached experiences during mealtime,</p>
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		<p>and non-nutritive associations with food, which children grow to adopt as normal eating behaviour (Gucciardi et al., 2004). In spite of the expanding knowledge on eating disorders in South Asian women, there still remain gaps in understanding the sociocultural and psychological mechanisms that are involved. Currently there is lack of research examining the lived experiences of South Asian women with eating disorders, which can unpack some of the underlying sociocultural factors that are thought to impact eating disorder pathology in young South Asian women. This study aims to examine the lived experiences of young South Asian women to gain an understanding of how culture and gender is experienced from the perspective of South Asian women living in Western society using narrative inquiry. Also of interest is how their experiences have influenced the way they perceive their bodies and interact with their environment, including their eating behaviours and social interactions, and what impact this has on their physical and mental health. A study of this nature is an important contribution to the extant literature on eating disorders in South Asians, as there is a need for further exploration into these areas from the perspective of those who experience it firsthand, especially considering these issues have shown to have a significant effect on this population (Anand & Cochrane, 2005; Hill & Bhatti, 1993; Kennedy et al., 2004, Khandewal et al., 1995; McCourt & Waller 1996; Mumford et al., 1991; Reddy & Crowther, 2007).</p>
2.2	<p>Please provide a clear statement of the purpose and objectives of this project (one page maximum).</p>	<p>This study has the potential to contribute to the body of literature and begin to provide an understanding of how young South Asian women locate their experiences with eating disorders and body image perceptions in relation to current assumptions about eating pathology and mental health. A narrative study, which will examine the experiences of eating disorders and the daily struggles of South Asian-Canadian women, can inform new directions for health services and preventative programs tailored to meet the specific needs of this population that may not be attended to with existing programs that currently do not take into consideration ethnic differences. In addition, there is the potential to explore areas of further</p>

		education for women on eating disorder risks and prevention, and empower women to effectively manage their health in the face of cultural or gender struggles.
2.3	Describe the study design/methodology and attach all supporting documents in the attachments tab.	<p>This study will employ narrative methodology. Narratives are a type of qualitative research that involves hearing stories from the research subjects about a particular event in their life, an extended story about a particular aspect of one's life, or a story about one's life as a whole (Chase, 2005). The data collected from narratives are AUDIO RECORDED, transcribed and thematically organized to make inferences about the meanings that people attribute to particular experiences or events, and to understand the context from which people experience life/events and what those experiences are like for someone of a particular social group, gender, or culture (Fraser, 2004). Narrative research is the "relationship between the narrator's active construction of self...and the social, cultural, and historical circumstances that enable and constrain that narrative" (Chase, 2005, p. 667). Much can be learned from narratives, as the stories unfold in a natural sequence as told by the narrator/interviewee. Narratives have the ability to "gaze into the soul of another" (Chase, 2005, p.661) and gain an understanding of how subjects construct their lived experiences (Chase, 2005). The sequence of events and the manner in which a research participant chooses to tell their story can provide great depth to the information collected (Chase, 2005). How the story is told is of interest to the researcher, for example, the language that the narrator uses and the sequence in which events are discussed, in order to unpack the meanings that the subject has given to their experiences (Chase, 2005). The narrative structure is particularly helpful for the researcher to understand meanings by analyzing the way thoughts are organized, which can be telling of the cultural representations and modes of reasoning that people attribute to their experiences (Fraser, 2004). The process of conducting narrative interviews is an active one that engages the interviewee and evokes emotions that are pertinent to fully understanding life experiences (Chase, 2005). The narrator's voice is at the forefront as they tell their story from a first-person</p>

	<p>perspective, and the researcher allows the dialogue to be led by the narrator by choosing they way they to organize their thoughts to tell their story (Chase, 2005). The researcher's voice is secondary to the narrator, as the researcher's role is to reconstruct and analyze the stories told, and piece together information to create meaning from the narrator's stories (Chase, 2005). The aim of narrative research is to not only represent the "realities" of the research subjects and their experiences, but can also challenge taken-for-granted beliefs and assumptions about particular groups of people, cultures, or experiences (Fraser, 2004). The dynamic nature of narrative research makes it a suitable method for exploring eating disorders in South Asian women, by engaging in dialogue about a particular experience from the context of a specific culture and gender, which has not been explored in this way before. This study will use interviews to collect information about young South Asian women's experiences with eating disorders. The interview format allows the researcher and the research subject to engage in meaningful dialogue in which significant aspects of the narrator's life and particular events will be discussed (Lieblich et al., 1998). Subjects will discuss their experiences within the context of their South Asian cultural and gender roles, which can achieve one of the many goals of narrative study, including providing a context for understanding how eating disorders are experienced and the mechanisms involved in the development of eating disorders in this particular population (Chase, 2005). This researcher will guide the interview subjects toward specific aspects of their lives; specifically those aspects that have influenced disordered eating behaviours. General, semi-structured questions will be used to prompt subjects to discuss the topic of interest (Chase, 2005). TO BEGIN, VIGNETTES WILL BE USED AS AN ICE BREAKER AT THE BEGINNING OF THE INTERVIEWS TO INITIATE DISCUSSION ON THE TOPICS OF INTEREST. THIS WILL ALLOW THE SUBJECTS TO OPEN UP TO THE RESEARCHER ABOUT THIER OPINIONS ON THE TOPICS OF INTEREST, AND DEVELOP TRUST AND RAPPORT WITH THE RESEARCHER IN ORDER TO BEGIN DISCUSSIONS ABOUT THIER PERSONAL EXPERIENCES, OPINIONS, IDEAS, AND FEELINGS ABOUT THE TOPICS OF</p>
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	<p>INTEREST (BARTER & RENOLD, 1999) (SEE ATTACHED DOCUMENTS FOR A LIST OF EXPECTED TOPICS OF DISCUSSION, PROBING QUESTIONS, AND SAMPLE VIGNETTE TO BE USED IN THE INTERVIEWS). Subjects will then choose how to tell their stories, including, but not limited to: what topics to discuss; the sequence of events; and the meanings they attribute to their experiences, culture, gender and health (Chase, 2005). Deviations from the topic of interest are welcomed and viewed as relevant information for the study's purpose (Chase, 2005). THE INTERVIEWS WILL BE AUDIO RECORDED DURING THE INTERVIEW PROCESS AND THE RESEARCHER WILL ALSO TAKE NOTES ON A LAPTOP USING MICROSOFT WORD. WE WILL RECRUIT FIVE TO SIX SOUTH ASIAN WOMEN BETWEEN THE AGES OF 18-30, EACH OF WHOM WILL BE INTERVIEWED ON 2 OCCASIONS, MAKING FOR A TOTAL OF 10 INTERVIEWS. THE SAMPLE SIZE CHOSEN IS ADEQUATE TO GATHER INFORMATION RICH DATA ABOUT THE ROLE OF GENDER, CULTURE AND BODY PERCEPTIONS OF YOUNG SOUTH ASIAN WOMEN, AND GAIN AN UNDERSTANDING OF HOW WOMEN LOCATE THEIR EXPERIENCES WITHIN THE BROADER CONTEXT OF HEALTH. CONDUCTING TWO INTERVIEWS WILL ALLOW ME TO COLLECT THICK DESCRIPTIVE DATA AND ENSURE THAT THE WOMEN HAVE HAD AN OPPORTUNITY TO DISCUSS THEIR EXPERIENCES IN DEPTH. THE WOMEN WILL LIKELY BE FIRST GENERATION SOUTH ASIANS WITH PARENTS THAT HOLD MORE TRADITIONAL CULTURAL VALUES, VERSUS THOSE WHOSE PARENTS HAVE BEEN HIGHLY ACCULTURATED TO WESTERN CANADIAN CULTURE AND VALUES. THE PURPOSE FOR SELECTING FIRST GENERATION WOMEN IS THAT THEY ARE LIKELY TO IDENTIFY MORE WITH THEIR NATIVE CULTURE AND HAVE MORE EXPERIENCE WITH TRADITIONAL ASPECTS OF THE CULTURE VIA THEIR PARENTS, THAN WOMEN WHO HAVE BEEN RAISED WITH PARENTS THAT HOLD MORE WESTERN VALUES AND ARE LIKELY TO IDENTIFY LESS WITH THEIR NATIVE CULTURE. PARTICIPANTS WILL DISCUSS STORIES OF THEIR EXPERIENCES GROWING UP IN A SOUTH ASIAN FAMILY AND HOW IT HAS INFLUENCED THEIR EATING BEHAVIOURS AND BODY IMAGE PERCEPTIONS, THE ROLE GENDER HAS PLAYED IN INFLUENCING THEIR BEHAVIOURS, AS WELL AS</p>
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	<p>HOW IT IMPACTS THEIR PHYSICAL AND MENTAL HEALTH. PARTICIPANTS WILL BE RECRUITED FROM WESTERN UNIVERSITY'S VARIOUS SOUTH ASIAN CULTURAL ORGANIZATIONS, AND FROM SOUTH ASIAN COMMUNITY ORGANIZATIONS, SUCH AS THE SOCIAL SERVICES NETWORK BASED IN TORONTO, ON, WITH TIES IN LONDON, ON. THESE ORGANIZATIONS WILL BE CONTACTED TO HELP SUPPORT PARTICIPANT RECRUITMENT BY ADVERTISING TO ITS MEMBERS VIA EMAIL, ADS IN THE UNIVERSITY NEWSPAPER, COMMUNITY NEWSLETTERS, AND FLYERS. THE INTERVIEWS WILL BE AUDIO RECORDED WITH CONSENT FROM THE RESEARCH SUBJECT. IN THE EVENT THAT A PARTICIPANT DOES NOT CONSENT TO THE INTERVIEW BEING AUDIO RECORDED, THE RESEARCHER WILL ONLY TAKE NOTES ON A LAPTOP AND TRANSCRIBE THE INTERVIEW USING MICROSOFT WORD AS THE INTERVIEW TAKES PLACE. AUDIO RECORDINGS WILL BE TRANSCRIBED VERBATIM, REMOVING ANY IDENTIFYING INFORMATION ABOUT THE RESEARCH SUBJECT, SUCH AS NAMES, ADDRESSES ETC., AND REPLACED WITH PSEUDONYMS WHERE NECESSARY. PARTICIPANTS WILL BE INFORMED THAT THE INTERVIEWS ARE BEING RECORDED AND WILL ONLY BE RECORDED AFTER THE RESEARCHER HAS RECEIVED WRITTEN CONSENT FROM THE PARTICIPANT TO DO SO PRIOR TO EACH INTERVIEW. INTERVIEWS WILL TAKE PLACE IN A MUTUALLY AGREED UPON LOCATION BETWEEN THE PARTICIPANT AND RESEARCHER. UPON COMPLETION OF THE INTERVIEWS THE AUDIO RECORDINGS AND TRANSCRIPTS WILL BE KEPT ON FILE FOR UP TO FIVE YEARS. THE AUDIO FILES WILL BE PASSWORD ENCRYPTED FILE THAT WILL BE UPLOADED ONTO A CD UPON COMPLETION OF THE STUDY AND WILL BE STORED IN A LOCKED FILING CABINET IN THE PRIMARY INVESTIGATOR'S OFFICE LOCATED ON WESTERN UNIVERSITY'S CAMPUS. FOLLOWING TRANSCRIPTION, THE DATA WILL BE ANALYZED MANUALLY THROUGH A PROCESS OF LINE-BY-LINE THEMATIC CODING. EMERGENT THEMES AND CATEGORIES WILL NOT BE KNOWN UNTIL ALL OF THE DATA HAS BEEN COLLECTED AND TRANSCRIBED (LIEBLICH ET AL., 1998). THE PROCESS OF ANALYSIS WILL INCLUDE TRANSCRIBING INTERVIEWS FROM AUDIO TO TEXT, INTERPRETING</p>
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	<p>INDIVIDUAL TRANSCRIPTS, AND SCAN THE STORIES FOR DIFFERENT DOMAINS OF EXPERIENCES (FRASER, 2004). FRASER (2004) EXPLAINS THAT DOMAINS ARE USEFUL FOR EXPLAINING CERTAIN PHENOMENON, AND CAN BE USED “BY PROSPECTIVE RESEARCHERS WHO ARE INTERESTED IN EXAMINING THE SOCIAL ROLES OF STORIES BUT ARE BUT ARE NOT SURE HOW TO APPROACH THE TASK” (P. 191). NARRATIVE ANALYSES ARE APPROPRIATE FOR RESEARCH ON EATING DISORDERS IN SOUTH ASIAN WOMEN BECAUSE MUCH OF THE EXISTING RESEARCH STRUGGLE WITH FRAMING AN APPROACH ON THE TOPIC, AS THERE IS STILL LITTLE KNOWN ABOUT THIS PHENOMENA. THE ANALYSIS OF THE DATA WILL UNCOVER THE PROMINENT THEMES THAT EMERGE ACROSS STORIES AND WILL BE USED TO HIGHLIGHT THE SOCIAL AND CULTURAL DISCOURSES THAT INFLUENCE THE EATING BEHAVIOURS AND BODY PERCEPTIONS OF SOUTH ASIAN WOMEN. NARRATIVES DO NOT NEED TO PRODUCE GENERALIZABLE RESULTS; RATHER IT HELPS TO HIGHLIGHT PARTICULAR ASPECTS OF PEOPLES’ EXPERIENCES BY PLACING THEM WITHIN A BROADER FRAMEWORK (LIEBLICH ET AL., 1998). SINCE THERE IS NO NEED TO REACH SATURATION WITH NARRATIVE INQUIRIES, STUDIES HIGHLIGHT A RANGE OF NARRATIVES FROM PEOPLE WITH VARYING CHARACTERISTICS TO PROVIDE INSIGHT INTO THE RANGE OF CIRCUMSTANCES THAT ARE POSSIBLE WITHIN A PARTICULAR CULTURAL AND SOCIAL CONTEXT (CHASE, 2005). RESULTS FROM A NARRATIVE ANALYSIS ON THIS TOPIC CAN ALLOW FUTURE RESEARCHERS TO DELVE FURTHER INTO SPECIFIC AREAS THAT ARE FOUND TO BE PROMINENT IN THE EXPERIENCES OF YOUNG SOUTH ASIAN WOMEN (FRASER, 2004). TO ENSURE QUALITY AND TRUSTWORTHINESS IN QUALITATIVE RESEARCH, MORROW (2005) DISCUSSES THE PRACTICE OF REFLEXIVITY TO ENSURE AUTHENTICITY OF THE RESEARCH. REFLEXIVITY IS A PROCESS OF BEING SELF-AWARE AND SELF-REFLECTIVE IN ORDER TO ADDRESS BIASES OR PERSONAL ASSUMPTIONS THAT THE RESEARCHER MAY HAVE BASED ON THEIR OWN LIFE EXPERIENCES (MORROW, 2005). THE RESEARCHER CAN PRACTICE REFLEXIVITY IN SEVERAL WAYS, INCLUDING KEEPING A REFLEXIVE JOURNAL OF TO</p>
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		<p>RECORD THOUGHTS, EXPERIENCES, OR REACTIONS THAT THEY HAVE THROUGHOUT THE RESEARCH PROCESS (MORROW, 2005). WHEN IT COMES TO DATA ANALYSIS, A REFLEXIVE JOURNAL CAN BE USED AS A POINT OF REFERENCE AND ACKNOWLEDGE POTENTIAL BIASES THAT MAY EMERGE (MORROW, 2005). ANOTHER FORM OF REFLEXIVITY IS TO CONSULT WITH PEER DEBRIEFERS OR A RESEARCH TEAM TO PROPOSE ALTERNATE INTERPRETATIONS FROM A DIFFERENT FRAME OF REFERENCE, AND UNCOVER POTENTIAL BIASES (MORROW, 2005). REFLEXIVITY IS AN IMPORTANT PART OF THE RESEARCH PROCESS, AS IT HAS THE POTENTIAL TO CONTROL FOR SUBJECTIVITY IN QUALITATIVE RESEARCH (MORROW, 2005). BEING REFLEXIVE ABOUT EACH STEP OF THE RESEARCH PROCESS ENSURES TRANSPARENCY AND IMPROVES THE QUALITY OF THE RESEARCH. IN NARRATIVE RESEARCH, IT CAN BE CHALLENGING TO LIMIT SUBJECTIVITY, GIVEN THE HIGHLY INTERPRETATIVE NATURE OF THE DATA COLLECTED (TRACY, 2010). HOWEVER, PROVIDING THICK DESCRIPTIVE DETAIL, AND BEING HONEST ABOUT THE RESEARCH PROCESS BY PROVIDING DOCUMENTATION OF THE RESEARCHER'S SUBJECTIVITY WILL INCREASE THE CREDIBILITY AND RIGOR OF THE STUDY'S RESULTS (TRACY, 2010).</p>
2.4	Indicate the inclusion criteria for participant recruitment.	<p>I will recruit five to six South Asian women between the ages of 18-30 years old, each of whom will be interviewed on 2 occasions, making for a total of 10 interviews. The sample size chosen is adequate to gather information-rich data about the role of gender, culture and body perceptions of young South Asian women, and gain an understanding of how women locate their experiences within the broader context of health. Conducting two interviews will allow me to collect thick descriptive data and ensure that the women have had an opportunity to discuss their experiences in depth. THE PURPOSE OF NARRATIVE INQUIRIES ARE TO COLLECT THICK, DESCRIPTIVE DATA FROM A SAMPLE OF THE POPULATION OF INTEREST, IN ORDER TO UNCOVER MAJOR THEMES THAT EMERGE IN THE DATA THAT HELP TO UNDERSTAND AND EXPLAIN CERTAIN PHENOMENA (CHASE, 2005). A SAMPLE SIZE OF FIVE TO SIX PARTICIPANTS IS ADEQUATE FOR A NARRATIVE STUDY, GIVEN THE</p>

		<p>THAT THE DATA COLLECTED IS CONSISTS OF VAST AMOUNTS OF HIGHLY DETAILED INFORMATION ON THE TOPIC OF INTEREST. REACHING SATURATION OF THE DATA IS NOT NECESSARY, NOR POSSIBLE AT THIS STAGE OF RESEARCH ON THIS TOPIC, AS IT IS AN NEWLY EMERGING FIELD OF WORK AND IS BENEFICIAL TO EXAMINE A SMALLER SAMPLE POPULATION TO BUILD A FOUNDATION UPON WHICH TO BUILD ON AND EXPAND FUTURE RESEARCH. The women will likely be first generation South Asians with parents that have immigrated to Canada. Participants will discuss stories of their experiences growing up in a South Asian family and how it has influenced their eating behaviours and body image perceptions, the role gender has played in influencing their behaviours, as well as how it impacts their physical and mental health. THE WOMEN DO NOT HAVE TO HAVE BEEN DIAGNOSED WITH AN EATING DISORDER TO PARTICIPATE IN THIS STUDY. SINCE THE DIAGNOSES OF THE DISEASE ARE RARE AMONG THIS POPULATION, AND THE CRITERIA FOR CLINICAL DIAGNOSES ARE OFTEN NOT MET FOR WOMEN TO BE DIAGNOSED AND TREATED FOR AN EATING DISORDER (KEEL, 2010). FOR THIS STUDY WE WILL BE RECRUITING WOMEN THAT HAVE SELF-REPORTED TO HAVE EXPERIENCED ANY TYPE OF ABNORMAL EATING BEHAVIOUR AT SOME POINT IN HER LIFE. THESE TYPES OF EXPERIENCES ARE RELEVANT TO THIS STUDY, AS THE EXPERIENCES ATTRIBUTED TO THESE BEHAVIOURS ARE RELEVANT FOR UNDERSTANDING THE UNDERLYING FACTORS THAT INFLUENCE DISORDERED EATING BEHAVIOURS. Participants will be recruited from Western University's various cultural organizations, and from South Asian community organizations, such as the Social Services Network based in Toronto, ON, with ties in London, ON. These organizations will be contacted to help support participant recruitment by advertising to its members via email, ads in the university newspaper, community newsletters, and flyers.</p>
2.5	Considering your inclusion criteria listed above, what is the basis to exclude a potential participant?	<p>The purpose for the criteria above to recruit immigrant parents is because they identify with and hold more traditional cultural values than those that have been highly acculturated to Western Canadian culture and values. The purpose for selecting first</p>

		generation women is that they are likely to identify more with their native culture and have more experience with traditional aspects of the culture via their parents, than women who have been raised with parents that hold more Western values and are likely to identify less with their native culture. As this study examines cultural influences on gender, health and disordered eating behaviours, it is important that the participants identify with their South Asian heritage.
2.6	If using patients, describe the usual standard of care at the study site(s) for this population (including diagnostic testing, frequency of follow up visits).	N/A
2.7	Describe the study procedures and any study specific testing that will be done, outside of standard care.	N/A
2.8	How many participants over the age of 18 from London will be enrolled in your study? This includes hospital and university sites within London.	6
2.9	How many participants under the age of 18 from London will be enrolled in your study? This includes hospital and university sites within London.	0
2.10	How many participants over the age of 18 will be included at all study locations? (London + Other locations = Total)	6
2.11	How many participants under the age of 18 will be included at all study locations? (London + Other locations = Total)	0
2.12	Describe the method(s) of data analysis.	Narrative data can be thematically coded to uncover constructions that are common among across with similar characteristics (Chase, 2005). The interpretation of the data involves an iterative process of listening to the stories and examining them more generally, and focusing on how the narrator speaks and positions themselves within their story, for example, as a victim, perpetrator, antagonist, protagonist (Chase, 2005). These indications provide the researcher with valuable information about the role the subject places themselves in their own life, and helps to better

		<p>understand how people give meaning to their experiences (Chase, 2005). The data collected from interviews in this study will be transcribed verbatim and analyzed manually through a process of line-by-line thematic coding. Emergent themes and categories will not be known until all of the data has been collected and transcribed (Lieblich et al., 1998). The process of analysis will include transcribing interviews from audio to text, interpreting individual transcripts, and scan the stories for different domains of experiences (Fraser, 2004). Fraser (2004) explains that domains are useful for explaining certain phenomenon, and can be used “by prospective researchers who are interested in examining the social roles of stories but are but are not sure how to approach the task” (p. 191). Narrative analyses are appropriate for research on eating disorders in South Asian women because much of the existing research struggle with framing an approach on the topic, as there is still little known about this phenomena. The analysis of the data will uncover the prominent themes that emerge across stories and will be used to highlight the social and cultural discourses that influence the eating behaviours and body perceptions of South Asian women. Narratives do not need to produce generalizable results; rather it helps to highlight particular aspects of peoples’ experiences by placing them within a broader framework (Lieblich et al., 1998). Since there here is no need to reach saturation with narrative inquiries, studies highlight a range of narratives from people with varying characteristics to provide insight into the range of circumstances that are possible within a particular cultural and social context (Chase, 2005). Results from a narrative analysis on this topic can allow future researchers to delve further into specific areas that are found to be prominent in the experiences of young South Asian women (Fraser, 2004).</p>
2.13	How will the results of this study be made public?	Peer reviewed publication Thesis Presentation
2.14	If report to participants or other is selected above, please explain.	
2.15	Briefly provide any plans for provision of	This study adopt a narrative methodology and

	feedback of results to the participants.	involves two interviews per participant, the second of which is to ensure that the researcher has adequately understood the information shared in the first interview and to follow up on any additional issues that may have arisen between the first and second interview. During data collection, each participant will be asked if she would like to receive a copy of the thesis and/or any publications stemming from the project; which will be provided to each participant as she so desires.
2.16	Does this study include any use of deliberate deception or withholding of key information that may influence a participant's performance or response?	No
2.17	If YES in question 2.16 above, describe this process and justification including how the participants will be debriefed at some point. Please include the debriefing script.	

3. Risks and Benefits

#	Question	Answer
3.1	List any potential anticipated benefit to the participants.	Given the nature of data collection via one-on-one interviews, there is potential therapeutic benefits for the participants by allowing a safe environment to discuss personal issues that would not be discussed otherwise. There is the potential to discuss problematic health behaviours and offer referrals for support services and resources to help deal with issues. Participants may also feel a sense of pride in knowing that their experiences will be submitted to journals and conference presentations.
3.2	List the potential benefits to society.	The current body of literature has provided the groundwork necessary to explore key areas of further focus surrounding issue of eating disorders in South Asian women, such as parental control, struggles with internal control and autonomy, cultural conflict, and the effects of acculturation. These areas have all been identified as important factors that contribute to eating disorder risk, however the underlying issues are quite complex and not well understood at this point. This study has the potential benefit society by contributing to the literature by examining narratives of young

		<p>South Asian women who have experienced eating disorders and struggled with negative body self-perceptions to gain an understanding of the cultural, social, and psychological factors that have impacted their experiences with disordered eating. As South Asian populations continue to grow in Canada the prevalence of health and mental health issues among South Asians, including eating and body image disorders, will increase over time, and the demand for health services to meet this population's needs will continue to grow as well. For this reason, it is important to identify the health concerns that face this population, and examine the underlying factors that are cause for concern. Eating disorders among young South Asian women have been identified as a serious physical and mental health concern for this population. There is a need for research that identifies: the underlying factors that lead to eating disorders in South Asian women; ways to alleviate health disparities faced by South Asian women; and the need for appropriately tailored treatment and prevention strategies. This study has the potential to reveal more about the connections between culture, gender, and health, and can provide the groundwork necessary for the development of culturally appropriate prevention and treatment programs for South Asian women who are affected by eating disorders.</p>
3.3	List any potential risks to study participants.	<p>There are few risks involved for participants of this study. One potential risk includes negative emotional responses during one-on-one interviews given that some topics of discussion might elicit an emotional response by the participant discussing personal issues. In the event that a participant is experiencing distress, the researcher will provide a list of relevant supportive services for the participant to access if she needs. The researcher will also pause during a moment of potential distress, allow the participant to collect herself, and if possible continue the interview if the participant indicates that this is permissible and desirable. The researcher will reschedule any interview that is stopped before completion, in line with the participant's schedule and availability.</p>
3.4	List any potential inconveniences to daily activities.	<p>There are minor inconveniences to the participants' daily activities by participating in the study, namely</p>

		re-arranging work or school schedules to complete the interviews. Participants will be required to meet with the researcher on two occasions for a 2-hour duration each time, and will be given preference of where and when they would like to meet.
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4. Recruitment and Informed Consent

#	Question	Answer
4.1	How will potential participants be contacted and recruited? Select all that apply. A copy of all recruitment tools that will be used must be included with this submission in the attachments tab.	Advertising (i.e. poster or email or web-based). Please submit a copy of all advertisements. Other
4.2	Please explain in detail your selection from 4.1 and how it will be used to recruit participants.	Participants will be recruited from Western University's various cultural organizations, and from South Asian community organizations, such as the Social Services Network based in Toronto, ON, with ties in London, ON. These organizations will be contacted to help support participant recruitment by advertising to its members via email, facebook, ads in the university newspaper (The Gazette), community newsletters, or posters. THE UNIVERSITY CULTURAL ORGANIZATIONS THAT WILL BE CONTACT ARE: HINDU STUDENT ASSOCIATION, ISMAILI STUDENT ASSOCIATION, MUSLIM STUDENT ASSOCIATION, PAKISTANI STUDENT ASSOCIATION, SRI LANKAN STUDENTS' ALLIANCE, WESTERN INDO-CANADIAN STUDENT ASSOCIATION, ETHNOCULTURAL SUPPORT SERVICES, AND BRESCIA UNIVERSITY COLLEGE. . THE SRI LANKAN STUDENTS' ALLIANCE AGREED TO DISTRIBUTE INFORMATION TO ITS MEMBERS, AND ETHNOCULTURAL SUPPORT SERVICES PROVIDED INFORMATION REGARDING APPROPRIATE PERSONS TO CONTACT REGARDING THE DISTRIBUTIONS OF INFORMATION ONCE REB APPROVAL HAS BEEN RECEIVED. RESPONSES FROM ALL OTHER ORGANIZATIONS IS PENDING. PARTICIPANTS RECRUITED THROUGH THE SOCIAL SERVICES NETWORK WILL BE LONDON, ON RESIDENTS. IN THE EVENT THAT 5-6 PARTICIPANTS ARE NOT ABLE TO BE RECRUITED FROM LONDON, ON WITHIN THIS STUDY'S TIMEFRAME, THE SOCIAL SERVICES NETWORK WILL ASSIST WITH RECRUITING PARTICIPANTS FROM THE TORONTO AND THE GTA. THE SAMPLE SIZE WILL INCLUDE PARTICIPANTS

		FROM LONDON, ON AND/OR TORONTO, ON/GTA.
4.3	Which research team members will be recruiting the potential participants?	Co-investigator, Nazia Bhatti, will be responsible for all participant recruitment.
4.4	Does the Principal Investigator have any relationship to the potential participants?	No.
4.5	Does the person recruiting the participants have any relationship or hold any authority over the potential participants?	No
4.6	If you have answered "Yes" to either 4.4 or 4.5, please explain here.	
4.7	What method of obtaining consent will you use for participants? A copy of all forms being used for obtaining consent must be included with this submission.	Written Consent
4.8	If you are unable to obtain consent or assent using one of the methods listed above, please explain here.	
4.9	Indicate if you will be recruiting from any of the following groups specifically for this study. (select all that apply)	Employees or students of UWO or the institution where the study is being carried out
4.10	Will minors or persons not able to consent for themselves be included in the study?	No
4.11	If YES is selected in question 4.10 above, describe the consent process and indicate who will be asked to consent on their behalf and discuss what safeguards will be employed to ensure the rights of the research participant are protected.	
4.12	When the inability to provide an informed consent is expected to be temporary, describe what procedures will be used to regularly assess capacity and to obtain consent if the individual later becomes capable of providing consent. Alternatively, if diminished capacity is anticipated for the study population, describe the procedure used to assess capacity and obtain ongoing consent.	N/A
4.13	List any anticipated communication difficulties:	None

4.14	Describe the procedures to address any communication difficulties (if applicable):	
4.15	Indicate what compensation, if any, will be provided to subjects. For example, reimbursement for expenses incurred as a result of research, description of gifts for participation, draws and/or compensation for time. Include a justification for this compensation.	Participants will be provided with a small monetary honorarium of \$20.00 per interview, to compensate them for their time and participation in the study. This amount is the standard rate in qualitative research. The honorariums will be provided at the end of the interviews to avoid any prospect of the payment being perceived as coercive. However, if a participant needs to stop the interview before its completion, they will still receive the \$20.00 as a token of their time and participation.

5. Confidentiality and Data Security

#	Question	Answer
5.1	Are you collecting personal identifiers for this study?	Yes
5.2	Identify any personal identifiers collected for this study.	Full name Telephone number Email
5.3	If you checked any of the personal information in 5.2 above, please explain and justify the collection of this identifier.	Full names will be collected in order to address communications via telephone or email between the researcher and the participant. Given the intimate nature of narrative data collection, addressing the participant by name creates a more personable relationship with the study subject which is an important aspect of the narrative data collection process. Telephone and emails will be collected in order to contact the participant to set up meetings. THE PERSONAL INFORMATION IDENTIFIED ABOVE WILL NOT BE DOCUMENTED IN TRANSCRIPTIONS OF THE INTERVIEWS IN ORDER TO PROTECT THE IDENTITY OF THE RESEARCH PARTICIPANTS. ALTERNATELY, PSEUDONYMS AND/OR CODES WILL BE USED IN PLACE OF ACTUAL PERSONAL INFORMATION WHERE REQUIRED. IN ADDITION TO THE ABOVE IDENTIFIED PERSONAL INFORMATION TO BE COLLECTED, WE WILL ALSO COLLECT THE PARTICIPANTS AGES IN ORDER TO REPORT AGE RANGE OF PARTICIPANTS FOR REPORTING PURPOSES. WE WILL NOT COLLECT DATES OF BIRTH TO PROTECT THE IDENTITY OF THE PARTICIPANTS.

5.4	Where will information collected as part of this study be stored? (select all that apply)	Laptop Memory stick Off-site (specify below)
5.5	If you have indicated any of the locations in question 5.4, please specify here.	The researcher will store all data files AND backup copies on AN ENCRYPTED flash (USB) drive THAT WILL BE STORED IN A LOCKED FILING CABINET IN THE PRIMARY INVESTIGATOR'S OFFICE ON WESTERN'S CAMPUS along with a copy on the password protected DropBox online database.
5.6	If identifiable participant information is stored on a hard drive or portable device, the device must be encrypted. Describe encryption being used.	Interview transcripts will be transcribed on the researcher's personal laptop. The laptop is accessible via password. Data files will be password protected in order to open each file. ALL IDENTIFYING INFORMATION WILL BE REMOVED FROM THE TRANSCRIBED INTERVIEWS THAT ARE STORED ON THE LAPTOP AND A MASTER LOG CONSISTING OF PARTICIPANTS NAMES, PSEUDONYMS/STUDY ID'S, CONTACT INFORMATION, AND AGE WILL BE CREATED AND KEPT ON FILE. THIS LOG WILL ALSO BE KEPT IN A LOCKED FILING CABINET IN THE PI'S OFFICE ON WESTERN'S CAMPUS. Backup files will be stored on a memory stick and on DropBox, an online database storage website that is accessible using a user ID and password that only the researcher (Co-investigator) has access to. The files that are uploaded to the memory stick and DropBox will also be password protected in order to open the file.
5.7	How will you record study data?	Data Collection Form
5.8	If you select "Other" in 5.7, please explain why here:	Data will be collected via one-on-one interviews and the questions that will guide the interviews will be on a sheet of paper or interview guide (which the researcher will bring to her to each interview and store on her password protected computer). Each interview will be recorded using a digital voice recorder. The voice recordings will then be transcribed to text, and the researcher will be doing all of the transcribing of the interviews. The voice recording WILL BE STORED ON A USB FLASH DRIVE IN THE PI'S OFFICE IN A LOCKED CABINET, and resulting transcribed AND CODED textual data will be stored on the researcher's password protected computer. THE RECORDING AND TRANSCRIPTIONS WILL BE DESTROYED 5 YEARS AFTER THE STUDY HAS BEEN COMPLETED, AND IN THE INTERIM WILL BE STORED IN THE PI'S OFFICE IN A LOCKED FILING

		CABINET.
5.9	Describe the coding system to protect identifiable information or explain why the data must remain identifiable.	Participant names will be removed from the data and replaced with an alternate identifier, such as "Subject A", "Subject B" etc. In the text, any information, such as family names, place of residence, etc., will be removed and/or modified to ensure the confidentiality and anonymity of the study participants.
5.10	How will you store and protect the master list, signed original letters of information and consent documents or other data with identifiers?	Paper file (Required Protection: Locked cabinet in locked institutional office) Electronic file (off-site)(Required Protection: Encrypted (specify software used))
5.11	If any options are selected above, please provide the specific details here.	Paper copies of consent forms will be signed by participants and filed by the Primary Investigator in a locked filing cabinet in an office at Western University.
5.12	How will you store and protect data without identifiers?	Data without identifiers will be stored: on a personal laptop, memory stick, and on DropBox, with all files being password protected to open each file.
5.13	If you plan to de-identify the study data, please describe the method of de-identification.	Participant names will be removed from the data and replaced with an alternate identifier, such as "Subject A", "Subject B" etc. In text, any information, such as family names, place of residence, etc., will be removed and replaced as appropriate as to not reveal the identity of the study participant.
5.14	How long will you keep the study data?	5 years following the presentation of the study's results
5.15	How will you destroy the study data after this period? (If applicable)	All data will be stored electronically, and file will be deleted off of the digital voice recorder, laptop, memory stick, and DropBox.
5.16	Does this study require you to send data outside of the institution where it is collected? This includes data taken off-site for analysis. Please note that Western/Robarts are considered off-site locations for hospital/Lawson based studies, and vice-versa.	No
5.17	Where will the data be sent?	
5.18	Does the data to be transferred include personal identifiers? If yes, a data transfer	No

	agreement may be necessary.	
5.19	List the personal identifiers that will be included with the data sent off-site.	
5.20	If you have answered yes to 5.18 please indicate how the data will be transmitted	
5.21	Please specify any additional details on data transmission below.	
5.22	Will you link the locally collected data with any other data sets?	No
5.23	If YES is selected in question 5.22 above, identify the dataset	
5.24	If YES is selected in question 5.22 above, explain how the linkage will occur.	
5.25	If YES is selected in question 5.22 above, provide a list of data items contained in the dataset.	
5.26	Will the data be entered into a database for future use?	No
5.27	If YES is selected in question 5.25 above, please specify where it will be stored, who the custodian will be, who will have access to the database and what security measures will be in place.	
5.28	Please list agencies/groups/persons outside of your local research team who will have access to the identifiable data and indicate why access is required.	N/A
5.29	Western University policy requires that that you keep data for a minimum of 5 years. Please indicate if you are keeping data in accordance to this policy, otherwise please comment on how your data retention will differ from University policy and why. If you will be archiving the data, please explain why and how here.	Data will be kept for 5 years in accordance with Western University's policy.

6. Conflict of Interest

#	Question	Answer
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6.1	Will any investigators, members of the research teams, and/or their partners or immediate family members function as advisors, employees, officers, directors or consultants for this study?	No
6.2	Will any investigators, members of the research team, and/or their partners or immediate family members have a direct or indirect financial interest (including patents or stocks) in the drug, device or technology employed in this research study?	No
6.3	Will any investigators, members of the research team, and/or their partners or immediate family members receive any personal benefit (apart from fees for service) as a result of, or connects to this study?	No
6.4	If YES is selected in any of the above, please describe the nature of the conflict of interest and how all conflict(s) of interest will be managed.	

7. Industry Sponsored Protocols

#	Question	Answer
7.1	Is this an industry sponsored protocol?	No
7.2	Billing Information - Company Institution:	
7.3	Contact Person:	
7.4	Email of Contact Person:	
7.5	Street Address:	
7.6	City:	
7.7	Country:	
7.8	Province/State:	
7.9	Phone Number:	
7.10	Fax:	
7.11	Contract and/or protocol reference number required:	

7.12	Additional Sponsor Reference or contact information:	
7.13	Do you wish to apply for a REB Administration Fee Adjustment/Waiver?	
7.14	If YES to question 7.13 above, provide a brief written explanation indicating how the funding will be used, who will own the data or any intellectual property arising from the agreement and indicate if there are any restrictions imposed upon the investigator by the sponsor and, if so, what they are.	
7.15	Do you agree to the Conditions for Industry Funded Research Investigators?	
7.16	Do you agree to provide supporting documents? (These can be added in the attachments section)	

8. Confirmation of Responsibility

#	Question	Answer
8.1	As the Principal Investigator I have read the Tri-Council Policy Statement 2 and Western University's Guidelines on Research Involving Human Subjects and agree to abide by the guidelines therein: http://uwo.ca/research/ethics/health_sciences/d_guidelines.html	Yes
8.2	I attest that all Collaborators working on this Research Study (co-investigators, students, post-docs, etc.) have reviewed the protocol contents and are in agreement with the protocol as submitted;	Yes
8.3	All Collaborators have read the Tri-Council Policy Statement 2 and Western University's Guidelines on Research Involving Human Subjects and agree to abide by the guidelines therein;	Yes
8.4	The Collaborators and I will adhere to the Protocol and Letter(s) of Information as approved by the REB;	Yes
8.5	Should I encounter any changes or adverse events/experiences, I will notify the REB in a timely manner.	Yes
8.6	If the Research Study is funded by an external sponsor, I will not begin the Research Study until the contract/agreement has been approved by the appropriate university, hospital, or research institute official.	Yes

8.7	Have you exported a copy of this submission to Word using the "Export to Word" button? Note that you will be unable to submit future revisions if this is not done.	Yes
8.8	Have you uploaded the following documents, if applicable, to the attachments tab? Incomplete submissions will be returned without being reviewed.	Letter(s) of Information and Consent Documentation Recruitment Materials

9. Confirmation of Responsibility - Student

#	Question	Answer
9.1	Is this a student project?	Yes
9.2	As the Student I have read the Tri-Council Policy Statement 2 and Western University's Guidelines on Research Involving Human Subjects and agree to abide by the guidelines therein: http://uwo.ca/research/ethics/health_sciences/d_guidelines.html	Yes
9.3	I will adhere to the Protocol and Letter(s) of Information as approved by the REB;	Yes
9.4	I will notify the Principal Investigator as soon as possible if there are any changes or adverse/experiences, violations/deviations in regards to the Research Study.	Yes

Attachments

Description	File Name	Version Date
Received Dec 5 2013. Recruitment Poster	Recruitment Postcard.pdf	04/12/2013
Received Dec 5 2013. LOI & Consent	Participant Informed Consent - Nazia Bhatti.doc	04/12/2013
received Dec 5 2013	104767 Orchard Protocol.htm	
Interview questions/script	Interview Questions.doc	13/02/2014
Revised Letter of Consent - added section on inclusion and exclusion criteria for participation	Participant Informed Consent - Nazia Bhatti.doc	13/02/2014
Topics for discussion in interviews	Topics and Questions.doc	13/02/2014
	104767 Orchard.pdf	15/01/2014



Use of Human Participants - Initial Ethics Approval Notice

Principal Investigator: Dr. Treena Orchard

File Number:104767

Review Level:Delegated

Protocol Title:A Narrative Study of Culture, Gender, and Health Discourses of Young South Asian-Canadian Women with Eating Disorders

Department & Institution:Health Sciences\Nursing,Western University

Sponsor:

Ethics Approval Date:April 23, 2014 Expiry Date:October 31, 2014

Documents Reviewed & Approved & Documents Received for Information:

Document Name	Comments	Version Date
Letter of Information & Consent		2014/04/22
Recruitment Items		2014/04/22
Instruments	Interview Questions	2014/04/22
Instruments	Topics and Questions	2014/04/22
Western University Protocol		2014/04/22

This is to notify you that The University of Western Ontario Research Ethics Board for Health Sciences Research Involving Human Subjects (HSREB) which is organized and operates according to the Tri-Council Policy Statement: Ethical Conduct of Research Involving Humans and the Health Canada/ICH Good Clinical Practice Practices: Consolidated Guidelines; and the applicable laws and regulations of Ontario has reviewed and granted approval to the above referenced revision(s) or amendment(s) on the approval date noted above. The membership of this REB also complies with the membership requirements for REB's as defined in Division 5 of the Food and Drug Regulations.

The ethics approval for this study shall remain valid until the expiry date noted above assuming timely and acceptable responses to the HSREB's periodic requests for surveillance and monitoring information. If you require an updated approval notice prior to that time you must request it using the University of Western Ontario Updated Approval Request Form.

Members of the HSREB who are named as investigators in research studies, or declare a conflict of interest, do not participate in discussion related to, nor vote on, such studies when they are presented to the HSREB.

The Chair of the HSREB is Dr. Joseph Gilbert. The HSREB is registered with the U.S. Department of Health & Human Services under the IRB registration number IRB 00000940.

Ethics Officer to Contact for Further Information

This is an official document. Please retain the original in your files.

Appendix C

Interview Guide

Version Date: April 22, 2014

Opening Questions:

- I. Tell me a little bit about yourself: how old are you, your cultural background and generational status (i.e., first, second, third generation Canadian), what do you do (i.e. work, student)?

Questions about family:

- I. Can you tell me about your family? (probes: how many siblings do you have, do you live with your parents, relationship with parents and siblings?)
- II. Think about when you were growing up, how would you describe the way your parents raise you? (i.e. strict, cultural clashes, different rules for you versus your siblings (male or female, older or younger)
- III. *(follow-up with probes related to degree of autonomy and power struggles:* To what extent did/do you feel you have control over your own life? Can you explain the experience you have had with your parents over personal matters, like school/your education, your friends, your physical appearance (clothes, make-up, body)

Questions about culture and gender:

- I. Can you describe your views on how having two (or more) cultural identities impacts South Asian women living in a multi-cultural society.
- II. Can you explain some of the cultural expectations that South Asian females have: within the family unit, outside of the home/family?
- III. Have you ever had difficulties in your experiences balancing your South Asian identity with your Canadian identity? If so, can you explain your experience(s).
- IV. Can you explain some positive experiences you have had in terms of creating a South Asian-Canadian identity?
- V. Can you explain how your cultural identity has evolved as a South Asian woman as you have gotten older, with respect to how you are treated by family, or members of the community?
- VI. How do you feel cultural expectations (from family or community) have changed/evolved as you have gotten older?

Questions about self-perceptions:

- I. Physical appearance, beauty, and body issues can be hard to deal with. How would you describe your feelings about these complex aspects of your life?
- II. In what ways do you think cultural identity impacts South Asian women's views of beauty?
- III. To what extent does your cultural identity influence the way you view your own body and physical appearance?

Questions about eating behaviours:

- I. Can you explain what role food and eating have as part of your cultural identity?
- II. To what extent does your culture impact what you eat and your eating patterns?
- III. Has your cultural orientation to food ever affected your eating habits? If so, in what ways has it affected your eating?
- IV. How has growing up with South Asian and Canadian cultural influences impacted the way you think about food and eating?
- V. Have you ever strayed from your usual eating behaviours to a degree where it has affected your health? If so, can you describe what sorts of eating behaviours you engaged in and how it affected you.
- VI. What types of resources or people do you rely on for support during difficult times dealing with eating and body related issues?

(probes: family influences, friends, external influences such as media)

Appendix D

Vignette

24 year-old, New York native, Nina Davuluri, became the first Indian-American Miss America in 2013. Following the announcement of her win, social media sites were ablaze with hateful, racist messages expressing the public's disapproval of the judges decision to crown her the title of Miss America. Messages expressing feelings that Nina is "not American", her ties to terrorist groups, calling her 'Arab', and negative remarks about her physical appearance were the topics of messages floating around Twitter.

<http://www.buzzfeed.com/ryanhatesthis/a-lot-of-people-are-very-upset-that-an-indian-american-woman>

<http://www.foxnews.com/entertainment/2013/09/16/new-miss-america-to-be-crowned-in-atlantic-city/>

<http://www.miamiherald.com/2013/09/20/3639820/miss-america-controversy-overshadows.html>

What will be asked to/of the participants:

Questions may not be asked in this order (below) depending on how the conversations unravel.

Questions in relation to vignette:

1. Are you familiar with the controversy surrounding Nina Davuluri, Miss American 2013?
 - a. Participant will be provided some information (a vignette) about the controversy over an East Indian woman winning the 2013 Miss America beauty pageant if they are unfamiliar with the story
2. Do you think she should have won?
 - a. Following up to response: Why do you think that?
3. How do you feel about the backlash she received for winning the crown?
4. Do you think the American public are justified in their comments regarding her win? (participants will be shown Twitter comments made in response to her win)
5. What are your thoughts when you see this picture of Nina? (show participant a picture of Nina when she was plus sized next to her Miss America swimsuit picture)
 - a. ---probe question about the role of body image in competition and pressures to be thin???



- b. Which picture do you like more?
 - c. What do you think she did to lose weight?
6. If you had the opportunity would you enter a beauty pageant?
- a. Follow up: Why? or Why not?
 - b. Women will respond with reasons why or why they would not enter a pageant. For example, they are likely to mention that they are not thin enough to enter a pageant (considering they have reported having eating/weight issues in the past in order to participate in the study). This will open up the discussion about views on their own body.
 - c. What are your thoughts on South Asian women entering competitions where they are judged on their appearance?

Appendix E

Recruitment Poster

University of Western Ontario-School of Health Studies

Would you like to take part in a study about gender, the body, health and eating behaviours?

Purpose:

To examine Canadian-South Asian women's perspectives and experiences through your personal narratives and stories.

Expectations:

Participants are being asked to participate in 2 one-on-one interviews that are 1-2 hours in length.

The project is open to:

- Canadian-South Asian women (Indian, Pakistani, Bangladeshi, Sri Lankan)
- First generation, either born in Canada or living in Canada for the majority of your life
- Between the ages of 18-30 years old
- Have experienced abnormal patterns of eating at some point in your life

Your perspectives and experiences are greatly valued.

This study has received Research Ethics Approval through Western University.

If you would like more information about the project and are interested in taking part, please contact:

Nazia Bhatti at:

Appendix F

DSM-V Eating Disorder Classifications

DSM-V Classification	Classification Criteria
Anorexia Nervosa	<ul style="list-style-type: none"> • Persistent restriction of energy intake leading to significantly low body weight (in context of what is minimally expected for age, sex, developmental trajectory, and physical health). • Either an intense fear of gaining weight or of becoming fat, or persistent behaviour that interferes with weight gain (even though significantly low weight). • Disturbance in the way one's body weight or shape is experienced, undue influence of body shape and weight on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight. <p>Subtypes: Restricting type binge-eating/purging type</p>
Bulimia Nervosa	<ul style="list-style-type: none"> • Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following: <ul style="list-style-type: none"> ◦ Eating, in a discrete period of time (e.g. within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances. ◦ A sense of lack of control over eating during the episode (e.g. a feeling that one cannot stop eating or control what or how much one is eating). • Recurrent inappropriate compensatory behaviour in order to prevent weight gain, such as self-induced vomiting, misuse of laxatives, diuretics, or other medications, fasting, or excessive exercise. • The binge eating and inappropriate compensatory behaviours both occur, on average, at least once a week for three months. • Self-evaluation is unduly influenced by body shape and weight. • The disturbance does not occur exclusively during episodes of Anorexia Nervosa.
Binge Eating Disorder	<ul style="list-style-type: none"> • Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following: <ul style="list-style-type: none"> ◦ Eating, in a discrete period of time (e.g. within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances. ◦ A sense of lack of control over eating during the episode (e.g. a feeling that one cannot stop eating or control what or how much one is eating). • The binge eating episodes are associated with three or more of the following: <ul style="list-style-type: none"> ◦ eating much more rapidly than normal ◦ eating until feeling uncomfortably full ◦ eating large amounts of food when not feeling physically hungry ◦ eating alone because of feeling embarrassed by how much

	<ul style="list-style-type: none"> one is eating <ul style="list-style-type: none"> feeling disgusted with oneself, depressed or very guilty afterward Marked distress regarding binge eating is present. Binge eating occurs, on average, at least once a week for three months Binge eating not associated with the recurrent use of inappropriate compensatory behaviours as in Bulimia Nervosa and does not occur exclusively during the course of Bulimia Nervosa, or Anorexia Nervosa methods to compensate for overeating, such as self-induced vomiting.
Pica	<ul style="list-style-type: none"> Persistent eating of non-nutritive substances for a period of at least one month. The eating of non-nutritive substances is inappropriate to the developmental level of the individual. The eating behaviour is not part of a culturally supported or socially normative practice. If occurring in the presence of another mental disorder (e.g. autistic spectrum disorder), or during a medical condition (e.g. pregnancy), it is severe enough to warrant independent clinical attention.
Rumination Disorder	<ul style="list-style-type: none"> Repeated regurgitation of food for a period of at least one month. Regurgitated food may be re-chewed, re-swallowed, or spit out. The repeated regurgitation is not due to a medication condition (e.g. gastrointestinal condition). The behaviour does not occur exclusively in the course of Anorexia Nervosa, Bulimia Nervosa, BED, or Avoidant/Restrictive Food Intake disorder. If occurring in the presence of another mental disorder (e.g. intellectual developmental disorder), it is severe enough to warrant independent clinical attention.
Avoidant/Restrictive Food Intake Disorder (ARFID)	<ul style="list-style-type: none"> An Eating or Feeding disturbance as manifested by persistent failure to meet appropriate nutritional and/or energy needs associated with one (or more) of the following: <ul style="list-style-type: none"> Significant loss of weight (or failure to achieve expected weight gain or faltering growth in children). Significant nutritional deficiency Dependence on enteral feeding or oral nutritional supplements Marked interference with psychosocial functioning The behavior is not better explained by lack of available food or by an associated culturally sanctioned practice. The behavior does not occur exclusively during the course of anorexia nervosa or bulimia nervosa, and there is no evidence of a disturbance in the way one's body weight or shape is experienced. The eating disturbance is not attributed to a medical condition, or better explained by another mental health disorder. When it does occur in the presence of another condition/disorder, the behavior exceeds what is usually associated, and warrants additional clinical attention.
Other Specified Feeding or Eating Disorder (OSFED)	According to the DSM-5 criteria, to be diagnosed as having OSFED a person must present with a feeding or eating behaviours that cause clinically significant distress and impairment in areas of functioning, but

	<p>do not meet the full criteria for any of the other feeding and eating disorders. A diagnosis might then be allocated that specifies a specific reason why the presentation does not meet the specifics of another disorder (e.g. Bulimia Nervosa- low frequency).</p> <ul style="list-style-type: none"> • The following are further examples for OSFED: <ul style="list-style-type: none"> • Atypical Anorexia Nervosa: All criteria are met, except despite significant weight loss, the individual's weight is within or above the normal range. • Binge Eating Disorder (of low frequency and/or limited duration): All of the criteria for BED are met, except at a lower frequency and/or for less than three months. • Bulimia Nervosa (of low frequency and/or limited duration): All of the criteria for Bulimia Nervosa are met, except that the binge eating and inappropriate compensatory behaviour occurs at a lower frequency and/or for less than three months. • Purging Disorder: Recurrent purging behaviour to influence weight or shape in the absence of binge eating • Night Eating Syndrome: Recurrent episodes of night eating. Eating after awakening from sleep, or by excessive food consumption after the evening meal. The behavior is not better explained by environmental influences or social norms. The behavior causes significant distress/impairment. The behavior is not better explained by another mental health disorder (e.g. BED).
Unspecified Feeding or Eating Disorder (UFED)	<p>According to the DSM-5 criteria this category applies to where behaviours cause clinically significant distress/impairment of functioning, but do not meet the full criteria of any of the Feeding or Eating Disorder criteria. This category may be used by clinicians where a clinician chooses not to specify why criteria are not met, including presentations where there may be insufficient information to make a more specific diagnosis (e.g. in emergency room settings).</p>

Source: Eating Disorders Victoria - <https://www.eatingdisorders.org.au/eating-disorders/what-is-an-eating-disorder/classifying-eating-disorders/dsm-5>

Curriculum Vitae

Name: Nazia Bhatti

Post-secondary Education and Degrees: University of Western Ontario
London, Ontario, Canada
2003-2009 B.H.Sc.

Related Work Experience

Project Coordinator
The University of Western Ontario
2008-2015

Teaching Assistant
The University of Western Ontario
2012-2014

Health Educator
Halton Hills Family Health Team
2015-Present